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EDITORIAL

HAS THE OUTLOOK OF THE SPECIALIST BECOME TOO NARROW

LESLIE E. DAUGHERTY, M.D.

There is a growing concept that Otolaryngology is not merely the study of the ears, nose and throat; but also the overall science concerned with people in health and disease.

This editorial is the argument against those who say, "that the outlook of the specialist has become too narrow."

On the contrary, the modern specialist must be familiar not only with his system, but all systems. There is a reciprocal relationship between the ear, nose and throat and the ophthalmic system, the endocrine glands and the psyche as well. One has only to note, the relationship between the female reproductive tract and the urogenital system.

No longer can the Ophthalmologist consider the eye as a specific and distinct entity. Its relationship with the general body is so highly integrated, that one has only to look into the fundus or eyegrounds and get a concept of the general physical economy.

While the ophthalmoscope is not commonly used, it is becoming a major factor in the training of every medical student. It should be a part of the internist's armamentarium, along with the electrocardiograph; because today it is being used by the young general practitioner as commonly as the stethescope was in the past medical generation.

Every young physician is trained to look at the eardrum, at the throat, at a sinus and at the thyroid. Thus more and more, he is already labeling the disease, when he sends the patient to the specialist for consultation.

Consultations are three to one more frequent, than in the past. Antibiotics, steroids and the like, have helped bring this about, no doubt.

Once the diagnosis has been made, the treatment is often times simple and prognosis is just around the corner.

We all know the many cases of allergy that have been labeled with a diagnosis of sinusitis, when the nasal sinuses were only acting as cesspools of retained secretions and not infected of course; or at least until an intercurrent exanthematous disease or upper respiratory tract infection accentuated the symptoms.

In the past, it was said that a specialist was one who knew more about less and less, until he finally knew almost everything about nothing.

This today, is no longer the case. Today, he must know more and more about everything. He must read the Journals and the new books, and attend the Clinics, where patients are discussed from every angle and standpoint; where an interplay and exchange of ideas is expressed. He is conversant in every consultation, whether with internists, neurosurgeons, or general practitioners. He must know about the latest treatment, if not the treatment itself, in every situation.

Recently, in a consultation where a blood dyscrasia was the topic, I was delighted to see the interplay and exchange of ideas between the older and the younger physician. The older physician knew about everything, but the younger physician knew why and the specialist was able to correlate and direct throughout the emergency.

One must note the trend in recent textbooks; that is, the deletion of older textbook illustrations. Modern drawings, photographs and graphs are taking their place, so that the subject is clear today for all who may care to learn the specialized techniques.

There is no reason why the general practitioner could not assume more responsibility in many conditions, that were considered formerly in the category of the specialist. Along with this new role, an added responsibility must be accepted by the general physician. He must no longer label definite entities with such loose terms, as sinusitis, conjunctivitis, laryngitis, otitis etc.

At the present rate, three billion dollars will be spent this year for drugs in the United States alone. Many of which, are unnecessary and harmful, if not dangerous to the patient.

Change of climate, was a term used very frequently and many patients were sent all over the world in search of something they did not find, only to discover that they had left their friends, lost their money and often times, their health, in this search for the unknown. One has only to look in the Medical Journals, to see the multiplicity of nasal drops, sprays, eardrops, eyedrops, mouthwashes and gargles ad infinitum, to see that the physician often times is only looking for the end of the rainbow. The end of the rainbow is not to be found in the prescription bottle, however. It must be found by way of an accurate diagnosis. There is a laboratory test for almost every disease, as well as X-ray findings. These alone, are no better than the paper fortune obtained in a chewing gum machine for one cent.

Nothing takes the place of a careful history. A common complaint of the lay public, is that the physician will not let them tell their story; and an equally common complaint of the physician, is that the patient wants to talk too long about his illness. There is a happy medium, however, and one can judiciously direct the patient's thoughts and keep the subject well in hand, if one is really interested.

An equal complaint, is that the physician does not send whatever notes he has about the patient, along with the patient, for consultation. All too often, the consulting specialist is asked to see a patient in the hospital, where he finds that the history has not been recorded; if taken, where nothing but the laboratory findings are present, where X-ray findings do not tell if the condition is acute, past or present and leaves one only to conjecture whether the referring physician desires help, or praise.

Many procedures have fallen into one of two classes and practitioners assume themselves either for or against, all too often.

Thus, we have seen those who have said, "all tonsils should be removed in childhood," and those who say "all children should retain their tonsils."

The specialist looks to the end results. When the Otologist sees the patient with irrecoverable loss of hearing from conduction deafness—and the history and examination reveal that the tonsils and adenoids were removed too late, or not at all—he asks himself

the question, "Has he been derelict in his consultation? Has he failed to convey the facts?"

When the Ophthalmologist sees a progressive myopia in a child who has never had a cycloplegic examination—and often times refracted by a non-medical practitioner—does he fear that by speaking the truth, he will no longer enjoy further opportunities for consultation?

On the contrary, the outlook of the specialist is broader and broader. He is keenly aware of the most intricate connection with medicine in general. He is a consultant in every respect and should be regarded as such.

7 Washington Street
Cumberland, Maryland

JENKINS-KEOUGH RETIREMENT PLANS*

Millions of our employed fellow citizens, happily, find that income tax laws help them retire. Working for others rather than for themselves, they participate in employee pension plans. Moneys paid into these trusteed or insured plans by an ememployer are deemed a business expense and constitute a tax deduction for the employer. More important to the employee is the fact that he does not have to pay any income tax on his company's contribution, or the increments earned thereon, until the benefits actually are paid out to him.

But ten million self-employed taxpayers have no such tax deferment under which to save. When we work for ourselves, we not only are expected to provide for our own retirement, we are told we must expect to do so out of post-tax rather than pre-tax dollars.

To bring about tax equality for the self-employed Representatives Jenkins (R-Ohio) and Keogh (D-N.Y.) in H.R.9 and H.R.10, have introduced identical bills which would permit the self-employed individual taxpayer in computing income tax each year to deduct from the adjusted gross income, (on self-employment income) ten per cent of the net earnings from self-employment or $5,000, whichever is less, if used for payments by him to obtain retirement income for himself or payments to his beneficiary or his estate. The total deductions allowed could not exceed $100,000 during the taxpayer's lifetime.

For persons between the ages of fifty and seventy, in addition to the maximum deductions permitted, an additional ten per cent of the above formula could be added for each year over age fifty. Retirement deposits would be deductible if paid to a restricted retirement fund operated by a bank or into a life insurance company plan providing for annuity, endowment or life insurance contract or a combination of these, but not for term insurance.

Under this plan at maturity periodic payments made to the taxpayer after age sixty-five or to his beneficiary would be treated as ordinary income for tax purposes. Provision is made for the right to borrow from deposited funds or to withdraw them prior to age sixty-five or to allow for a lump payment at age sixty-five. For these privileges there is a slight tax penalty above that provided for when periodic payments are made at maturity.

The present economy drive in Congress may make the outlook of these measures dark. However, support of these bills by a vigorous group of self-employed is this year better organized and spearheaded by the American Thrift Assembly with offices at 1025 Connecticut Avenue, N.W., Washington, D. C.

* Upon request, supplied by Dr. C. H. Maxwell, Assistant Director, Washington Office, American Medical Association.

SPECIAL ARTICLES

ALLEGANY COUNTY MEDICAL SOCIETY FOUNDING 1884

LESLIE E. DAUGHERTY, M.D.

The year, 1884, was an epochal year for Allegany County medicine.

Dr. John M. Williams, was a delegate from the Allegany County Medical Society to the Medical and Chirurgical Faculty of the State of Maryland. In 1883, a year earlier, only two physicians are mentioned in the transactions, as members of the Medical and Chirurgical Faculty from Allegany County. Two years prior to that, or in 1882, the great Koch of Berlin, had announced the discovery of the tubercle bacillus and the young William Henry Welch, who was now thirty-four years of age, was appointed a member of the Faculty of Johns Hopkins University; which had been in existence only seven years. The near great Osler, was one year his senior, age thirty-five, and was to join Hopkins four years later, in 1888.

Medically speaking, great events were in the offing. As far back as 1868, there is on record that a Medical Society was in existence in Allegany County and no doubt, there were smaller organizations of Physicians already in existence for many years previously.

Whether this Medical Society of Allegany County of 1868, was a Component Society of the Medical and Chirurgical Faculty, the records do not show.[1] It is certain however, that there was an Allegany County Medical Society and in 1884 that Dr. John M. Williams, of Lonaconing, Md. was a delegate to the Medical and Chirurgical Faculty. It had been fourteen years (April 21, 1870), since the Semiannual Meeting of the Medical and Chirurgical Faculty had met in Cumberland and it was not to meet again in Cumberland, until 1894, ten years later; at the urging of the Component County Society.

Allegany County medicine was not without representation in the Medical and Chirurgical Faculty even prior to this; for in 1873, or eleven years previously, Dr. Charles H. Ohr, a Cumberland physician from Allegany County, was president of the Faculty and three years previous to that, in 1870, there were twenty-seven tax-paying physicians in Allegany County; or one physician for 1,430 persons in a County population of 38,500. Eighty-seven years hence, in 1957, the population is now 89,556. The registered voters in Allegany County are at present, 40,497. There are at present in Allegany County, sixty one practicing physicians. In 1875, nine members of the Faculty listed their addresses from Allegany County. Thus in seventy-five years, or from 1800 to 1875, the physician population had grown from three to twenty-seven and the civilian population, from 6300 to 38,500.

It is worthy of note, that while there were only nine members of the Faculty residing in Allegany County in 1875; seventy-five years before that time, three physicians from Allegany County were among the founders of the Medical and Chirurgical Faculty in 1799, namely; George Lynn, Benjamin Murrow and James Forbes, among a list of one hundred and one physicians, who had applied to the Maryland Legislature for a charter for a corporation to be called the Medical and Chirurgical Faculty of Maryland.

By approximately 1885, the last surviving member of the incorporators, the original secretary, Dr. Ashton Alexander, of Baltimore, passed away.

In 1884, the "near" renowned William Henry Welch, of New York, sensing the medical knowledge coming from Germany, departed for that country to study with the famous Koch, of Berlin; in the fundamentals of bacteria, which was to play such a great role in the advancement of medicine.

Johns Hopkins Hospital was not to open until five years later (1889) and the Medical School not to be inaugurated until 1893, or nine years later. These events were cataclysmic in that they were the forerunners of the influence of Johns Hopkins Medical School and Hospital, not only on the medicine of Western Maryland, but of the entire state and nation and world at large, for years to come.

Medical teaching took on the flavor of the German atmosphere. The teaching of medical students until that time, consisted mainly of short courses in medical schools, both private and institutional, supplemented by short hospital stays; the latter all too infrequently.

Now came ward teaching at the bedside. By the establishment of a chair in pathology, with Welch at the head, medical training was to be centered around pathology.

Carl Koller had just announced the discovery of cocaine as an agent for anesthetizing the eye and the "later to be" great surgeon, William S. Halsted began experimental work with cocaine in the blocking of nerve trunks, namely; regional anesthesia. Up to that time, general or no anesthetics at all, were the rule for surgery. Halsted did not reach Maryland until 1889, or five years later. A year earlier, the "next to be great" Osler, had already accepted an appointment on the Johns Hopkins Hospital Staff, to be opened the next year. Osler tempered by his stay at the University of Pennsylvania, represented the English school of thought; while Halsted cherished the medical education as practiced in Germany. Thus were united the two great forces then existing, in stimulating medical progress and thought, in the Free State of Maryland.

The "later to be great" Howard A. Kelly, who graduated from the University of Pennsylvania Medical School, in 1882, broke his ties in Pennsylvania and followed Welch, Osler and Halsted, to Johns Hopkins. Osler described him as the "man with nimble fingers." Kelly was only thirty-one years old, but already a great surgeon. Johns Hopkins Hospital then only needed a head for its body and Henry M. Hurd came from Michigan to Maryland, to head one of the greatest Medical Institutions in America.

The history of Johns Hopkins Hospital is noteworthy for four happenings. Namely;[2] the establishment of a nurse's training school in connection with the hospital, as an integral and indispensable part. Secondly, the publishing of scientific progress. Thirdly, efficient hospital administration in the care of patients and fourthly, a dedication to clinical and laboratory research.

Bedside teaching was to become the order of the day. Dog surgery was to precede and follow human surgery, and new techniques as they had never been known before, were to be devised.

The young Welch said, when talking to young men in later years as they departed for Europe, "Young man, you must get into contact with the great Teacher, then you will have an impression of the men and their work which you will never forget and everytime you read their writings, you will remember. Everything will be much more vivid to you." Thus, medical men all over America after receiving their training at home, visited the great Clinics in Germany, Austria and the British Isles; as a finishing course for their education.

Thus in 1884, just one hundred years after the first physician had located in Cumberland, Allegany County was established as a Component Medical Society, of the Medical and Chirurgical Faculty. The first physician who had located in Cumberland, was a Dr. Murray, coming from Annapolis to Cumberland, in 1784 and remaining there as late as 1814.

In 1884, the Society had thirty-one physicians and met once a month, in various towns throughout the County. It had a library of two hundred and thirty-one volumes. It is noteworthy, that the Medical and Chirurgical Faculty library in Baltimore, in 1884, had but 4,019 volumes, of which two hundred and seventy-seven were duplicates. There were practicing in Allegany County in 1884, thirty-five physicians and in Garrett County, four physicians. Cumberland had fifteen of those physicians, it being the largest town in Allegany County; while Oakland, the largest town in Garrett County, had two physicians.

Today (1957) Allegany-Garrett County Medical Society has neither a library, nor permanent home. Of all the physicians listed in 1884, not even a remote descendent of their families are physicians practicing in Allegany or Garrett Counties. A grandson of Dr. J. Jones Wilson, namely; Dr. Wilson Footer, practices in California and Dr. David Skilling, Professor of Internal Medicine, at Washington University, St. Louis, Missouri, is a grandson of the late Dr. J. D. Skilling, of Lonaconing, Md.

Those practicing in Allegany County in 1884, were: Doctors John B. Crawford, George E. R. Owens, John Watson Piper, all of Barton. In Cumberland, Doctors M. A. R. F. Carr, G. B. Fundenberg, W. F. Fundenberg, James A. Fechtig, P. A. Healey, W. H. McCormick, W. McGill, C. H. Ohr, E. H. Parsons, James Smith, S. P. Smith, O. M. Shindell, N. W. Wiley, D. P. Welfly, J. J. Wilson; in Frostburg: C. H. Brace, J. W. J. Englar, C. H. Getzendanner, T. J. Graham, J. M. Porter, W. H. Ravenscraft and M. M. Townsend. In Lonaconing: Doctors G. H. Marmion, G. E. Porter, J. D. Skilling, D. W. Williams, J. M. Williams; Mt. Savage: A. Thompson; Ocean: A. B. Price, A. G. Smith; Pekin, Horatio J. Dorsey and from Westernport, a Dr. Crawford.

Those practicing in Garrett County, which was only twelve years old at the time, were; Dr. E. H. Glodfelty, Accident; Doctor B. T. Keller, Grantsville, and in Oakland, Dr. E. H. Bartlett and Dr. J. Lee McComas.

Today—1957—the Allegany-Garrett area covers 1,094 square miles, with a population of 110,815. The medical area covers a radius of seventy-five miles, with a combined population of more than a hundred and fifty thousand people. Cumberland is the medical center of this territory and has long enjoyed the reputation for good medical care for the people it serves.

Southern Pennsylvania, Northern West Virginia and Western Maryland combined, supports Memorial Hospital, in Cumberland, Sacred Heart Hospital, in Cumberland; Miners Hospital, in Frostburg and Memorial Hospital, in Oakland. The Memorial Hospital, Cumberland, has a bed capacity of 255, with a Staff of sixty-two physicians and surgeons. Every field of surgery is covered, except brain and neurological surgery. A modern medical library has just been established, with all the current Medical Journals. It has a training school of 120 nurses and like most hospitals today, is overcrowded and in much need of being replaced by a more modern hospital. It was built in 1929.

The Sacred Heart Hospital, Cumberland, is a private institution of 134 beds, with a training school of 79 students and an attending Staff of 32 physicians and surgeons. Many of the physicians serve on the Staffs of both hospitals.

The Miners Hospital, in Frostburg, twelve miles from Cumberland, has a bed capacity of 62. It is the only general Hospital owned by the State. Efforts are now being made to discontinue it as a State owned Hospital and place it under a representative city group of citizens.

Memorial Hospital, of Oakland, is described in a separate article, by Dr. E. Irving Baumgartner, in this issue of the State Medical Journal.

7 Washington Street
Cumberland, Maryland

REFERENCES

1. Cordell: The Medical Annals of Medicine, 1779–1899, Baltimore—1903.
2. Fleming, Donald: William H. Welch and the Rise of Modern Medicine—Little, Brown & Company, Boston—1954.

SURGERY IN A SMALL HOSPITAL*

JOSEPH ALVAREZ, M.D., AND A. E. MANCE, M.D.

With the recent increase in small hospitals throughout the nation, there has been a proportionate need for specialists to staff these hospitals. There is a natural reluctance on the part of specialists to leave the comfort and security of their learned centers of medical education where they are supported by experienced consultants and well-organized and well-equipped hospitals. There is the feeling that going to a small community and a small hospital will markedly limit the amount and type of work that will be done. Certainly, there are some limitations, but with perseverance and hard work, many of these can be overcome.

One of the prime considerations is the caliber and type of laboratory facilities. There are no essential laboratory procedures that cannot be performed in a small laboratory. The Garrett County Memorial Hospital has available on a 24-hour basis the complicated blood chemistry determinations requiring the use of a flame photometer.

Another consideration is the matter of consultants. It is surprising how much guidance and moral support an understanding consultant can give over the telephone. In cases of emergency, there are few consultants who are not willing to take the time and trouble to help a colleague. In our hospital we are 60 miles from any city with a population of 30,000 or more. We are 100 miles from Pittsburgh and 200 miles from Baltimore. Yet, we have never lacked for competent consultants in any emergency. In 5 years of practice in this small community hospital, there has never been a refusal for a telephone consultation or a bedside consultation at any hour of the day or night. This is certainly a great tribute to the caliber of the American medical profession.

Equally important is the matter of equipment. Most small communities have an intense interest and considerable pride in their hospital. Community groups such as the Lions Club, Loar Hospital Women's Auxiliary, Rotary, Business and Professional Women's Club, and even individual prominent citizens feel a certain responsibility for improving the caliber of medical service. Many special instruments may be obtained in this manner. Below are listed some of the specialized instruments added over a period of 5 years to the Garrett County Memorial Hospital.

Albie Comper Fracture Table
Brown Dermatone
Bovie Electro-surgical unit
Brown Buerger Cystoscope
Pan-endoscope
Stern McCarthy Resectoscope
Proctoscope
"Luck" Bone Saw

Nursing care in a small country hospital is no different than that obtained in the largest hospitals, because of the high standards maintained by the American Nursing Profession.

Unfortunately, there are disadvantages in small country hospitals, and one is the absence of a full-time pathologist and radiologist. Few small hospitals can afford the services of these specialists. However, it is seldom that the part-time services of these specialists cannot be obtained. Here in Garrett County we have a well-qualified radiologist to read all X-ray films and do gastro-intestinal work one day a week.

Anesthesiology is another problem that must be compromised. A general surgeon working in a small country hospital must necessarily assume a greater responsibility because of these limitations. In our example, a general practitioner, co-author of this paper, has taken over the rôle of anesthesiologist. In a period of five years, he has given varied types of anesthesia without serious

* Garrett County Memorial Hospital, Oakland, Maryland.

complications. Spinal anesthesia is used extensively for abdominal and lower extremity surgery. Endotracheal anesthesia is used for head, neck, and chest surgery.

The lack of a resident or interne staff in a small community hospital naturally increases the burden of the general surgeon. However, this, I am convinced, is a blessing in disguise. It affords closer contact and more intimate knowledge of your patient, and I am sure, provides for fewer post-operative complications and a more gratifying patient-doctor relationship.

The general surgeon practicing in a small community hospital must have a broad training with special emphasis on Pathology, Radiology, and Anesthesiology. Below are listed the numbers and types of surgical operations performed by one surgeon in a small community hospital over a 5 year period. This is by no means a complete list of all of the work, as it does not include any of the out-patient load that he must carry. Some of the interesting cases which are encountered in the course of practice in a small hospital will also be described in this paper.

General Surgery

Appendectomy	122
Herniorrhaphy	93
Cholecystectomy	21
Cholecystectomy and Common Duct Exploration	16
Cholecystojejunostomy	4
Common Duct Explorations	1
Choledochoduodenostomy	1
Sphincterotomy—Trans-duodenal	1
Gastric Resection	
Total	3
Subtotal	9
Gastro-enterostomy	4
Repair of Perforated Ulcer	3
Gastrotomy	1
Ramstedt Pyloroplasty	1
Thyroidectomy	7
Thyro-glossal Cyst	1
Excision of Bronchial Cleft Cyst	1
Minor General Surgical Operations	34
Cholecystoduodenostomy	1
Abdominal Perineal Resection of Colon	2
Colon Resection	7
Colostomy	3
Small Intestine Resection	1
Radical Mastectomy	3
Splenectomy	4
Resection of Tail of Pancreas	1
Incision and Drainage of Abdominal Abscess	
a. Sub-phrenic	1
b. Appendiceal	1
c. Pelvic	3
Abdominal Exploration	11

Orthopedic Surgery

Open Reduction of Major Bones	
Humerus	4
Femur	39
Tibia	20
Patella	2
Radius or Ulna	5
Clavicle	3
Arthrotomy	
Knee	7
Elbow	1
Resections	
Head of Radius	1
Bone Grafts	
Thumb	1
Femur	1
Tibia	2
Humerus	1
Amputations	
Mid-thigh	1
Arm	1
Callender	3
Trans-Metatarsal	2
Minor Orthopedic Procedures	
Closed reductions, Bursitis, Tendon repairs, etc., requiring Operating Room Care	82

Obstetrics and Gynecology

Caesarian Section	6
Hysterectomy	
Total	10
Modified Subtotal (with wide conization of cervix)	16
Vaginal hysterectomy	10
Vulvectomy	1
Ectopic Pregnancies	2
Uterine Suspension	2
Perineal Repair	
Anterior and Posterior Repair	22
Posterior Repair	15
Watkins Interposition	5
Suspension of Vaginal Vault	3

Ovarian Cysts or Tumors	8
Minor Procedures, Dilatation and Curettage, Conizations, Insertion of Radium, etc.	201

Urology

Plastic Operations for Hydronephrosis	1
Partial Nephrectomy	1
Nephrectomy	2
Excision of large cyst from kidney	1
Nephro-lithotomy	2
Ureterectomy	1
Supra-pubic Cystotomy	10
Prostatectomy	
Retro-pubic	44
Supra-pubic	3
Transurethral	11
Transurethral Resection of Bladder Tumors	4
Minor Urological Procedures	157

Plastic and Facial Surgery

(Reduction of facial fractures, removal of tumors, minor skin grafts, excision of carcinomas, etc., requiring operating room care.)

Major—Excision of malignant melanoma with axillary dissection	1
Minor	66
Excision of varicose ulcers with skin grafting	4
Major Skin Grafts	
Split thickness	15
Pedicle	2
Minor split thickness and full thickness	16

Traumatic Surgery

Major Gunshot Wounds	5
Traumatic Amputation—Hand	1
Minor Trauma Requiring Operating Room Care	46

Eye, Ear, Nose and Throat

Tonsillectomy	19
Tonsillectomy and Adenoidectomy	154
Incision and Drainage; Peritonsilar Abscesses	5
Incision and Drainage; Posterior Pharyngeal Abscess	1
Excision of Nasal Polypi	2
Miscellaneous	10

Proctology

Hemorrhoidectomy	37
Excision of Fistulae	4
Excision of Anal Fissures	20
Anal Polypi (Large)	6
Miscellaneous	24

Vascular Surgery

Saphenous Vein Excisions (Strippings)	
Bilateral	31
Unilateral	5
Ligation of Common Carotid Artery	1
Ligation of Inferior Vena Cava	1
Saphenous Vein Graft to Brachial Artery	1

Thoracic Surgery

Closed Drainage of Chest	3
Repair of Traumatic Diaphragmatic Hernia	1

Neurosurgery

Compound Skull Fractures	3
Post-operative Mortalities	3

Major and Minor Operations Beginning October 26, 1951 and Ending November 29, 1956

		Total Operations for Year
Year 1951		
Major Operations	16	
Minor Operations	18	34
Year 1952		
Major Operations	128	
Minor Operations	118	246
Year 1953		
Major Operations	133	
Minor Operations	200	333
Year 1954		
Major Operations	134	
Minor Operations	200	334
Year 1955		
Major Operations	166	
Minor Operations	221	387
Year 1956		
Major Operations	172	
Minor Operations	255	427

Total Major Operations for Five Years	749
Total Minor Operations for Five Years	959
Total Major and Minor Operations for Five Years	1,708

Case Reports

No. 1. White male, age 43, admitted November 9, 1953. Two weeks previously, he had developed vague epigastric distress shortly after eating, with nausea and vomiting. There was vague localization of the pain to the epigastrium with radiation to the back. There was no history of malaria or exposure to malaria.

On November 9, 1953, he developed sudden severe abdominal pain. On hospital admission his blood pressure was 140/80. The abdomen was soft, doughy and tender; no rigidity and no masses. There was active peristalsis and no distention. Survey film of the abdomen revealed no gaseous distention and no free air under the diaphragm. Leukocytes 13,400; neutrophiles 82 per cent; hemoglobin 87 per cent; urine was negative.

On November 11, 1953, mild icterus of the sclera was noted. Blood chemistry was within normal limits. At 6 P.M. on November 11, 1953, he developed a sudden severe vascular collapse. He was resuscitated with great difficulty by large amounts of Levaphed and whole blood. There was marked distention of the abdomen. Hemoglobin shortly after resuscitation was 57 per cent.

He was taken to the operating room at 1 A.M. on November 12, 1953. Under nitrous oxide-oxygen-ether anesthesia, a left paramedian incision revealed the abdomen filled with blood. Approximately 3500 cc. of blood was aspirated. There were several rents in the splenic capsule, with profuse hemorrhage. The left half of the greater omentum appeared discolored and gangrenous. The pancreas was edematous. The liver was normal. A splenectomy was performed. The splenic vein was distended with organized clot. The splenic artery was patent. The left half of the greater omentum was resected. The left subdiaphragmatic space was drained through a lateral stab wound. Post-operatively, there was deepening icterus and profuse sero-sanguinous drainage from the stab wound. On November 24, 1953, the drain was removed, and by November 27 drainage had ceased with the icterus diminishing. He was treated post-operatively with anti-coagulants. On December 1, he developed complete anuria preceded by gross hematuria. On December 2 he developed polyuria, and then continued to make an uneventful recovery. He was discharged from the Hospital on December 9, 1953, to be continued on Dicumerol for approximately 6 weeks.

He has been followed closely for 3 years, and is completely asymptomatic.

No. 2. White male, age 42, admitted August 28, 1953. Two weeks before admission, he developed pain in the left lower leg with slight swelling. One week later he developed sudden severe right chest pain, followed shortly afterwards with left chest pain and a slight cough. Two days later he developed hemoptysis.

Physical examination was essentially negative, except for a small area of dullness at the base of the left lateral chest and moist rales in the right base posteriorly. There was pitting edema of the left lower leg, with a positive Homan's sign and calf tenderness. A diagnosis of thrombophlebitis and pulmonary emboli was made. X-ray examination was compatible with this diagnosis.

He was treated with anticoagulants, and was discharged from the hospital on September 9, 1953, completely asymptomatic. There was no residual edema of the left extremity and no chest pain. He was maintained at home on Dicumerol for six weeks with frequent prothrombin determinations, after which he was allowed to return to work, with Dicumerol being discontinued.

Four days after returning to work, he developed pain in the left thigh and a few hours later he developed sudden severe right lower chest pain. Physical examination revealed considerable distress with grunting respirations; dullness to percussion, harsh breath sounds, and moist rales in the right lateral chest. There was edema of the left leg from the toes to the inguinal region, most pronounced in the thigh. There was

tenderness over the femoral vein. The leg was warm with good arterial pulsations. Intercostal block afforded marked symptomatic relief. Anticoagulants were started. Several hours later he was awakened by sudden severe pain in the right chest. The area of dullness at the right base had extended. Under light sodium pentothal and local novocaine anesthesia, the left femoral vein was explored and found to be completely occluded with an organized thrombosis.

Therefore, under spinal anesthesia and in a reverse Trendelenburg position, the inferior vena cava was triply ligated extraperitoneally through a right muscle-splitting incision. Silk was used for the ligatures and the fourth lumbar sympathetic ganglion was removed. He made an uneventful recovery from surgery, and six weeks later, had only minimal edema about the right ankle after moderate exercise. Since then he has been working regularly and has very little residual disability.

No. 3. White male; age 43; admitted May 17, 1954. For several months he had been acting "queerly" on occasions, with disoriented speech. His family stated that he had had periods of dizziness during which he did not appear to be rational. Finally, a generalized convulsive seizure caused him to seek medical attention. A complete physical survey was performed by Dr. Alfred Van Ormer, of Cumberland, Maryland, during which he had consistent fasting blood sugar levels of less than 50 mgm. per cent; the lowest being 35 mgm per cent. He had complete absence of symptoms and a normal blood sugar on a high calorie diet.

On May 20, 1954, an abdominal exploration was performed through a curved transverse upper abdominal incision. A thorough exploration of the pancreas failed to reveal any evidence of tumor until the tail of the pancreas was mobilized and a small tumor was found near the hilum of the spleen. The tumor was not readily accessible. Therefore, the tail of the pancreas was resected.

The pathological report described a tumor-like mass, in the tail of the pancreas, which was pale and moderately firm and measured 1 x 1 x 2 centimeters. Microscopic examination resulted in a diagnosis of an islet cell adenoma of the pancreas. The patient has been followed more than two years, with no further manifestations of an abnormal sugar metabolism.

SUMMARY

Factors comprising a surgical practice in a small community hospital, and the variety of work that may be anticipated are reviewed. Approximately 5 years are required to become established in a small community.

101 Third Street
Oakland, Maryland

THE STORY OF THE GARRETT COUNTY MEMORIAL HOSPITAL

EUGENE IRVING BAUMGARTNER, M.D.

George W. Loar (1865–1946)—"A Wise and Understanding Heart"—so reads a bronze plaque on the wall of the front corridor at the Garrett County Memorial Hospital in Oakland, Maryland. And therein lies the catalytic spark behind the story of how a modern fifty-nine bed hospital came into being in Maryland's largest most western but least populated county.

It is true there had been two small sanitaria present in Oakland in the early part of this century, both of which were privately operated; however, because of expenses they were aban-

GARRETT COUNTY MEMORIAL HOSPITAL
Oakland, Maryland

doned. Accordingly, if a patient required hospitalization it was necessary for the ill person to make the, at times, difficult trip to Cumberland, Pittsburgh or Baltimore.

While the question of a hospital for Oakland had been discussed repeatedly during the 20's and 30's, nothing tangible developed because of lack of sufficient funds and interest. Such was the story until early in February 1946, when Mr. Ernest Ray Jones and John M. Jarboe, Executors of the estate of the recently deceased Mr. George W. Loar of Oakland, announced that under the terms of his will $170,000 had been left for the construction of a hospital to be built in Oakland to serve the people of Garrett County. So strong was the interest of Mr. Loar in the project that he had had an architect prepare some preliminary sketches. This had been done about two years prior to his death. He had further indicated the site where he felt the hospital should be located. This location being one which the town authorities had purchased as the possible site for a community building. The bequest carried with it certain stipulations which shall be mentioned. It was stated $160,000 was to be made available for construction—$10,000 for landscaping and $5,000 to assist in supporting the hospital during its opening period. The will stipulated, "the building to be of a design and type suitable and appropriate to the county and its ability to support and maintain the same." The hospital to be operated under the joint supervision of the County Commissioners and a five person committee. It further provided the bequest must be accepted within a one year period or else it would revert to another legatee.

Within a short time the Board of County Commissioners set up an advisory committee of representative citizens to study the advisability of accepting the bequest. This committee investigated the matter and on March 27, 1946 met with the commissioners and recommended the generous offer be accepted.

At the regular meeting of the Board of County Commissioners on April 2, 1946 they went on record as accepting the bequest according to the various stipulations.

Since the manner of procedure of the commissioners was pioneering in nature, and the board of the Garrett County Memorial Hospital as set up is somewhat unique as compared to the type of operating boards in other county hospitals in Maryland, I believe it is of interest to record in total the resolution as adopted by the Commissioners in accepting responsibility for the hospital and its continued maintenance. Their actions were as follows:

"Whereas by the last will and testament of George W. Loar dated 7/18/44 and a codicil thereto date 7/10/46

the same bequeathed to the executors of the will the sum of $160,000 for the erection and equipping of a hospital at Oakland in Garrett County with the provision that upon completion of said hospital the said executors would transfer legal title thereto to the County Commissioners and

Whereas the said executors were further authorized to expend additional amounts not to exceed $10,000 for landscaping purposes and a further sum of $5,000 for the support and maintenance of said hospital during the period immediately following the completion and

Whereas the said last will and testament further provided that before said executors should take any steps toward erection of said hospital that the County Commissioners of Garrett County should agree by proper resolution regularly made and recorded to accept, maintain and support said hospital under the joint control of the County Commissioners and an advisory committee consisting of two members appointed by the two Oakland banks, the president of the Town Council of Oakland, the president of the Garrett County Chapter of the American Red Cross and a representative of the medical profession residing in Garrett County and

Whereas an advisory committee appointed by this board has made careful investigations with regard to hospitals in general and the advisability of the County Commissioners of Garrett County accepting such bequest and recommended such action be taken and

Whereas the Mayor and Town Council of Oakland have agreed to convey to the County Commissioners of Garrett County the site of said hospital—same being known as the Helbig property

Now therefore be it resolved that the County Commissioners of Garrett County this second day of April 1946—that this said bequest be accepted and that the County Commissioners agree to accept and maintain said hospital when transferred to it under the joint control of the County Commissioners and the Advisory Committee and said hospital to be known as the Garrett County Memorial Hospital

In accordance with the above resolution and in consideration of the erection and conveyance of said hospital to the County Commissioners do hereby covenant and agree with Ernest Ray Jones and John M. Jarboe, Executors of the last will and testament of the late George W. Loar that upon the erection and conveyance of the said hospital to be known as the Garrett County Memorial Hospital that they will accept and provide management jointly with the committee provided for in the said will and will support and maintain same and further through annual levies hereafter to be levied that they will provide such financial support as may be necessary and which may not be available from other sources to the end that said hospital shall and will be properly supported."

And thus the initial steps were taken toward the realization of the construction of a hospital for Garrett County as its future financial status guaranteed.

Shortly afterward a survey was made of the hospital needs of the County by Mr. Herbert Fritz, Director of the Maryland Hospital Survey Committee. As a result of discussions with Mr. Fritz, as well as a study of per bed construction costs, it became apparent to those committed to the responsibility of the erection that the funds available under the Loar bequest would not be sufficient to take care of the construction and equipment of the structure, and that the county should attempt to investigate the possibility of obtaining funds under the then proposed Hill-Barton Bill for hospital construction.

On August 13, 1946, the Hill-Barton Bill became law, when signed by President Truman; later the amount Maryland would have available was announced and also that Federal aid would be on the basis of one dollar for each two dollars raised locally. With the probability of Federal aid in the offing, Mr. J. J. Baldwin, an architect of Washington, D. C., was commissioned to draw up preliminary plans for the structure. These were approved after proper consideration by the hospital Board of Governors which organization had been set up by an act of the legislature to conform with the terms of the will and the resolution of the Commissioners. The preliminary plans provided for a structure with an overall size of 125 × 40 feet. It was to be a three story and basement fireproof building, capable of taking care of 40 patients, with two operating rooms, delivery room and other necessary rooms and facilities for adequate patient care. A portion of the first floor was to be set aside as a County Health Center and thereby house the County Health Department.

It was announced early in February 1947 by the State Health Department that Garrett

County had been given the number one priority for Federal funds. Additional information was forthcoming from the Survey Commission to the effect that Garrett County was entitled to 40 hospital beds—this being pro-rated on the State's need of 9,208 hospital beds.

Following further study pertaining to the cost of construction, it became necessary to set up a local campaign to raise additional money, in order to obtain sufficient Federal funds to take care of the ultimate financial needs and to provide the type of structure and equipment necessary. To provide these additional funds an enthusiastic group met in Oakland on February 11, 1947, and a goal of $80,000 was set. The response on the part of Garrett Countians, not only present residents but past residents as well, was most gratifying and an eminently successful drive ended with the sum of $102,000 realized. In passing, it might be mentioned, all this was received through local aid and not a cent was spent for promotion or expense for the drive.

On February 19, 1947, the Board of County Commissioners adopted a motion to sponsor an application for the granting of Federal funds. At this time preliminary estimates were received for construction costs: the low was $426,000.

Early in May of 1947 the final plans were approved by both the State and Federal agencies for a 34 bed structure to have as patient facilities 4 cribs, 8 bassinets, 4 private rooms, 9 semi-private and 3 four bed wards. It was announced the Federal grant would be $163,000. It was estimated the total cost for the structure would be about $536,000—of this about $445,000 for construction; $54,500 for equipment and the balance for architect fees and other expenses incidental to supervision and construction. The contract for construction was awarded to Moyer Brothers of Altoona, Pennsylvania and on August 12, 1948 ground was finally broken for the building.

Mr. John Francis Gallagher of Cumberland was named as administrator on September 22, 1949 and charged with the duty of purchasing the equipment and operating the institution.

Late in 1949 Mr. J. J. Baldwin became ill and was forced to withdraw as architect. His place was taken by Mr. Fred Tilp of Washington. Thinking of possible future additions the utilities of the structure were designed for possible expansion to a 65 bed facility and certain corridor walls were constructed in such a manner that they might be easily knocked out for the addition of a wing in the rear should this become necessary.

On May 15, 1950 the Garrett County Memorial Hospital opened its doors for patients. The total amount having been expended at this time was $525,000. Your author of this report is happy to have had the honor of delivering the first baby in the new hospital.

The staff was composed of Drs. E. I. Baumgartner, James H. Feaster, Thomas F. Lusby, Andrew E. Mance and J. W. Wenzel of Oakland—Dr. Charles E. Smith of Terra Alta, W. Va.—Drs. Harold and Blanch Miller of Eglon, W. Va. In addition there was a courtesy staff composed of physicians and surgeons from Cumberland, Md., Morgantown, W. Va. and Phillipi, W. Va. In 1952 Dr. Joseph Alvarez moved to Oakland and became a member of the active staff.

From the beginning the hospital has been successful in taking care of the medical and surgical needs of the county and surrounding territory.

Further gifts and bequests have been granted the institution. In 1953 Mr. John H. Miller of Bloomington, Md., set up a trust fund that provides for the hospital to receive $3,000 a year for a period of 25 years.

Mr. Gallagher served as administrator until early in 1952, when he resigned to accept a similar position at the Community Hospital, Meyersdale, Pa. He was succeeded by Miss Irene Sharp of Houtzdale, Pa.

Early in 1953 it was realized an addition would

be necessary because of crowded conditions. Patients were being placed in the corridors, and there was overcrowding in the obstetrical suite. Accordingly, as a result of action taken by the Board of Governors, Johannes and Murray, architects of Silver Spring, Md., were consulted and preliminary plans drawn for the addition of a wing to provide for 25 additional patient beds, as well as increased bassinet space in the nursery.

An act was passed by the State Assembly granting the County Commissioners the right to borrow $200,000 as its contribution for additional construction. Application was made for another Hill-Barton grant. This was forthcoming, and in 1954 a contract was let for the construction of the new wing providing for 25 additional beds, as well as space for other necessary ancillary services. The cost of construction of the wing was $300,322.83. Equipment costs were $30,029.02.

The completed plant is carried on the books by our auditors as having an overall value of $908,971.61. Of this amount, the actual costs to the taxpayers of the county for construction and equipment has been just a little over $200,000. At the present time we have 4 four-bed adult wards, 1 four-bed pediatric ward, 16 two-bed semi-private rooms, and 7 private rooms, for a total of 59 beds. In the nursery, there are 26 bassinets, 4 incubators and 1 isolette. In addition, the solaria on the two upper floors are so constructed that, should the need arise, they can be converted easily into five-bed wards. Our obstetrical and operating suites are air-conditioned, as well as both nurseries. In addition, the nursery has modern incubators, including two isolettes. With the addition of the new wing, which has been occupied since August 1955, the County Health Department now occupies half of the first floor of the new wing. Their facilities, which have their own entrance and waiting room, are more ample and entirely separated from the hospital.

The hospital was visited by Dr. J. W. Nelson, of the Joint Accreditation Board, in May 1956. At the present time we have provisional accreditation. It is our hope that means may be taken to insure complete accreditation by the time of the next inspection.

Miss Sharp was succeeded by Mr. Henry W. McComas, Jr., as administrator on October 15, 1956. Mr. McComas is the son of the late Dr. Henry W. McComas, a well known practitioner of the county.

The author of this report in addition to being an active member of the staff has been associated with the administrative end of the hospital since its inception, first as a member of the advisory committee and later as a member of the Board of Governors, by virtue of being president of the town council of Oakland. The personnel of our Board of Governors, while somewhat unique in its composition, has functioned quite well. While there have been differences of opinion, at no time has there been any evidence of political pressure associated with the operation of the hospital. We, here in Garrett County, are very proud of our hospital and feel we are most fortunate in having it. Forever will we remember the kindness and thoughtfulness of our original benefactor—Mr. George W. Loar.

25 Alder Street
Oakland, Maryland

Scientific Papers

INFECTIOUS MONONUCLEOSIS COMPLICATED BY HEPATITIS AND PERICARDITIS

A Case Report

SAMUEL M. JACOBSON, M.D., F.A.C.P.

Infectious mononucleosis in its usual form is considered a benign and self limited disease. However, it may be acute or chronic and it may be mild or end in death (1).

Pleural effusion (2) and encephalitis (3) have been reported as complications of infectious mononucleosis.

Jaundice as a complication was first described by Mackey and Wakefield in 1926 (3). Since then many excellent reports have shown the prevalence of jaundice as a complication of infectious mononucleosis. In addition, hepatitis has been found in sub-clinical infectious mononucleosis (4) and hepatitis in varying severity has been reported with and without jaundice (5) (6) (7).

Cardiac signs and symptoms are uncommon (3) (12) (14). Wechsler et al. in 1946 found one case in an epidemic which exhibited subjective symptoms of cardiac involvement, cardiac enlargement and a lengthened P-R interval (8). Logue and Hansen also found a first degree heart block in a patient with infectious mononucleosis (12).

Graybiel and Evans found electrocardiographic evidence in one of their patients suggesting pericardial involvement which returned to normal with convalescence (9) but this complication is considered rare by Soloff and Zatuchni (10). Jaffe et al. however, found electrocardiographic changes in 41% of their cases of infectious mononucleosis (11). Various electrocardiographic changes have been described: first degree heart block; second degree heart block; T wave changes both in amplitude and inversion, and premature beats.

Cases are rare in which there is hepatic and cardiac involvement in the same patient at the same time with infectious mononucleosis. Kass and Robbins reported such evidence found at autopsy (6). It is of interest therefore, to report such a case that recovered from infectious mononucleosis and had complications involving the liver and heart.

Report of Case

M. E. A. was a well oriented, seventeen year old, single, white, female, who was admitted to the Memorial Hospital on July 23, 1953 complaining of fever, backache and questionable jaundice.

Small discrete non-tender posterior cervical glands were palpable, especially on the right side, as were discrete glands in both axillae and in the right inguinal region.

The tonsils were missing. There was no visible evidence of jaundice.

In the third left interspace close to the sternum one heard a pericardial friction rub. A grade 4 systolic rumble was heard in the pulmonic area.

The liver, spleen and kidneys were not palpable. Otherwise the physical examination was not remarkable. Laboratory results are shown in Chart I. Serological tests were negative for Weil Felix reaction for Typhus or Spotted fever,

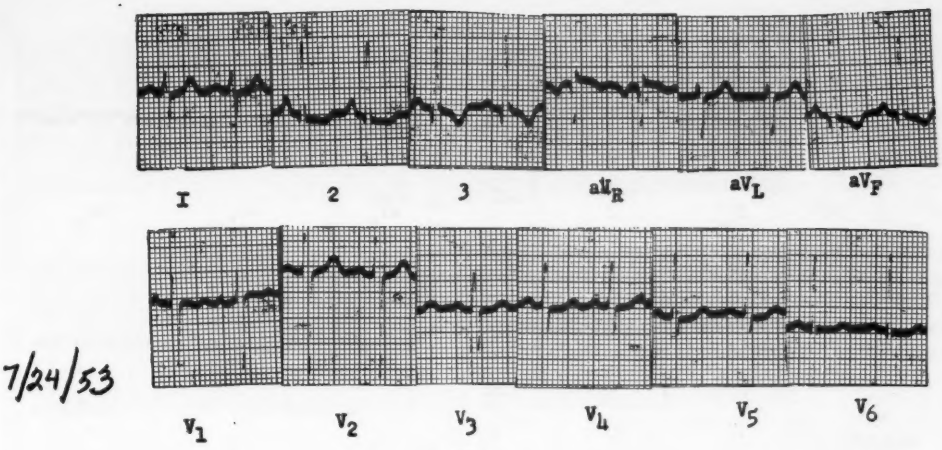

FIG. 1

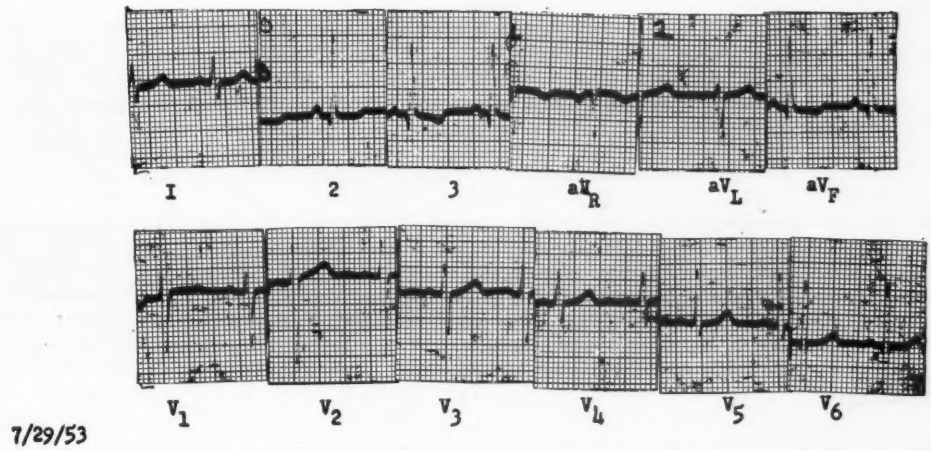

FIG. 2

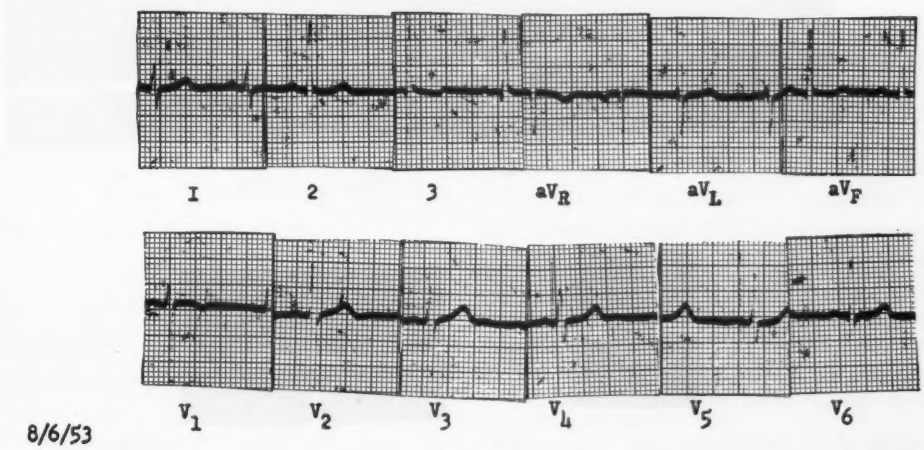

FIG. 3

The T wave changes are interpreted as due to subacute pericarditis with possibly some subpericardial myocardial involvement. The subsequent electrocardiograms reproduced in sequence show the progress towards the normal electrocardiogram.

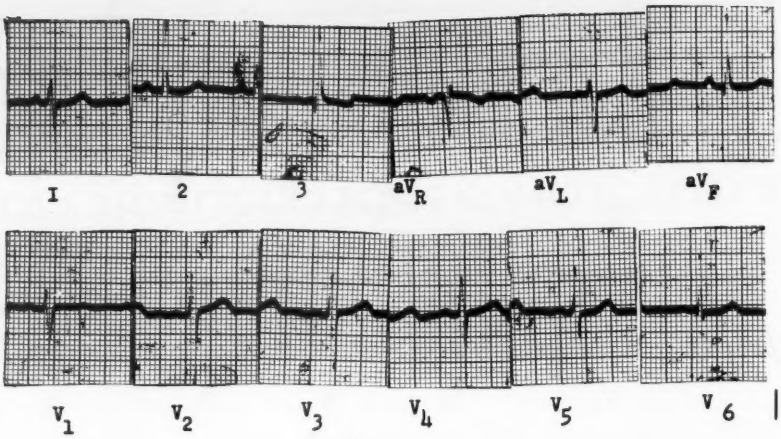

FIG. 4

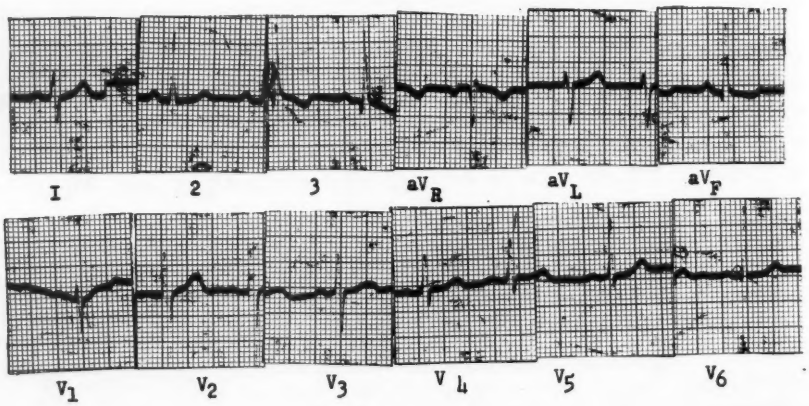

FIG. 5

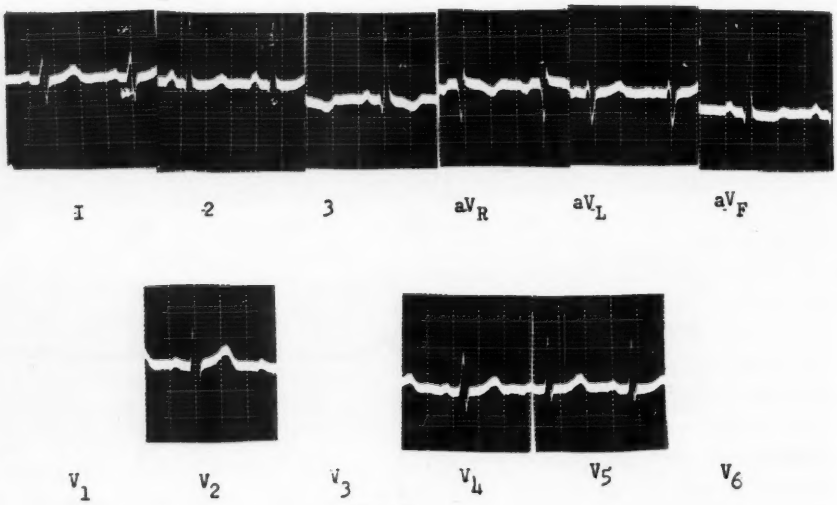

FIG. 6

CHART I

Date 1953	R.B.C. Million	W.B.C. Thous.	HgB %	C.I.	Neut.	Eosin.	S.M. Mono	Urine Urobilin	Urine Urobilinogen
7/23	4.2	15.1	75	.90	5		95	Neg.	Pos.
7/27	3.9	11.4	68	.98	20		80		
8/14	4.2	3.3	75	.89	55	1	44	Neg.	Neg.
8/24	4.1	7.6	76	.92	37	1	62	Neg.	Pos.

Date 1953	Blood Sugar Mg. Per 100 ml.	Blood Urea Mg. Per 100 ml.	Blood Urea Nit. Mg. Per 100 ml.	Icteric Index	Van den Bergh	Cholesterol Mg. Per 100 ml.	Cephalin Floc. 24 hrs.	Cephalin Floc. 48 hrs.	Heterophile Agglutin. for Infect. Mononuc.
7/23	99	20	9	7	Direct	169			Lost in transit
7/27							++	+++	7/30 Pos. 1:160
8/14				5	Delayed		0	+−	8/3 Neg.
					Indirect		+−	+−	8/10 Pos.
8/24					Indirect				1:160
									8/19 Pos. 1:80
									8/24 doubtful 1:20

Proteus OX19 positive 1:40, Proteus OX2 negative, no reaction for Typhoid or Undulant Fever.

The roentgenologist reported the lung fields clear and the heart shadow normal.

The electrocardiograms done in the hospital are reproduced. The evolution from that of acute pericarditis to the normal is apparent.

The patient responded well to treatment with oral tetracycline; lipotropic substance; synthetic Vitamin K; cholagogues; multivitamin tablets; powdered Brewers' yeast; ferrous sulphate and a high protein, high carbohydrate, low fat diet.

On September 4, 1953—or about 7 weeks after her initial illness—the following laboratory results were obtained in the office:

Icteric Index—6.4
Van den Bergh—Indirect Reaction
Prothrombin Time—100%
Bromsulphalein Test—5 min. 12% of dye retained; 30 min. free of dye.
Urobilinogen and urobilin—negative
Cholesterol—170 mg. %
Cephalin Flocculation—24 hours one plus; 48 hours two plus

Blood count:
RBC—4,100,000
WBC—9,000
Hgb—12.5 gm. 81%
PMN—49
SM—51

Heterophile agglutination—negative for infectious mononucleosis.
Electrocardiogram—normal

SUMMARY

A case of infectious mononucleosis in a seventeen year old, white, girl is reported with two complications occurring concurrently: acute pericarditis and hepatitis. She responded well to the usually accepted form of treatment.

50 Pershing Street
Cumberland, Maryland

BIBLIOGRAPHY

1. WISNER, H. J.: The Complications and Diagnosis of Infectious Mononucleosis, Journal Kansas Medical Society **53:** 566-573, 1952.
2. VANDER, J. B.: Plural Effusion in Infectious Mononucleosis, Annals Internal Medicine 41, **1:** 146, 1954.

3. Ream, C. R., and Hessing, J. W.: Infectious Mononucleosis Encephalitis, Annals Internal Medicine 41, **6:** 1231, 1954.
4. Watson, J., Johnson, P., Kahn, J., and Stone, F. M.: Subclinical Infectious Mononucleosis with Hepatitis, Archives of Internal Medicine **88:** 618, 1951.
5. De Marsh, Q. B., and Alt, H. L.: Hepatitis without Jaundice in Infectious Mononucleosis, Archives of Internal Medicine **80:** 257, 1947.
6. Kass, E. H., and Robbins, S. L.: Severe Hepatitis in Infectious Mononucleosis, Archives of Pathology **50:** 644, 1950.
7. Bennett, H. D., Frankel, J. J., Bedinger, P., and Baker, L. A. P.: Infectious Mononucleosis with Hepatitis, Archives of Internal Medicine **86:** 391, 1950.
8. Wechsler, H. F., Rosenbloom, A. H., and Sills, C. T.: Infectious Mononucleosis: Report of an Epidemic in an Army Post, Archives of Internal Medicine **25:** 113, 1946.
9. Graybiel, A., and Evans, W. F.: Electrocardiographic Evidence of Cardiac Complications in Infectious Mononucleosis, American Journal of Medical Sciences **211:** 220, 1947.
10. Soloff, L. A., and Zatuchni, Jacob: Infectious Mononucleosis Associated with Symptoms of Acute Pericarditis, Journal of American Medical Association 152, **16:** 1530, 1953.
11. Jaffe, H. L., Field, L. E., and Master, A. M.: The Electrocardiogram in Infectious Mononucleosis, New York Journal of Medicine **48:** 1382, 1948.
12. Mulligan, J. L.: Infectious Mononucleosis with Cardiac Involvement, The Journal of the Kentucky State Medical Association 53, **1:** 34, 1955.
13. Mackey, R. D., and Wakefield, E. G.: The Occurrence of Abnormal Lymphocytis in the Blood of a Patient with Jaundice (Infectious Mononucleosis—Glandular Fever), American Journal of Clinical Medicine **4:** 727, 1926.
14. Houck, G. H.: Involvement of Heart in Infectious Mononucleosis, Editorial, American Journal of Medicine 14, **3:** 261, 1953.

THE USE OF ELECTRO-CONVULSIVE THERAPY (ECT) AS AN OFFICE PROCEDURE IN THE TREATMENT OF DEPRESSIVE STATES

RICHARD W. TREVASKIS, Jr., M.D.

Since 1950, 271 patients have been treated in our office and received 2,511 electro-convulsive treatments. Over 90 per cent have obtained significant improvement or complete remission. For several years following the introduction of ECT* in this country in 1938, psychiatrists were inclined to regard the procedure as one suitable only to hospitalized patients; and, in consequence, a large group of relatively mild psychotics and depressed people were deprived of its benefits. Many types of somatic procedures have been temporary fads in psychiatry; however, ECT has grown in use from year to year and, to a large extent, has replaced other forms of shock therapy in most mental hospitals and other treatment centers. This is largely due to factors of: (1) comparative safety versus, e.g., insulin shock, (2) economy, (3) the need for fewer assistants. There appears to be little significant difference in the results of ECT versus the more formidable insulin shock treatment, although the latter still has its use in selective resistant cases.

The type of patient suitable for office ECT is limited. First, only voluntary patients that can and will cooperate can be accepted for treatment. An explanation of the risks involved are described to the patient and his relatives. A special form prepared by an attorney absolving the physician and his assistants of liability for any complications must be signed by the patient and witnessed before therapy is started.

Physical disease per se with few exceptions preclude the use of ECT. Patients with advanced myocardial disease are not treated nor those with recent major operations, as well as

* Electro-convulsive treatments will be referred to by the abbreviation ECT.

an occasional patient with a major disease of the osseous system. Pregnancy is not a contraindication, and we have given it in this series of ECT up to the time of term. Advance physical disease of any type is generally considered a contraindication for office ECT, and such patients are urged to enter a mental hospital. The ages of the patients ranged from 18 to 75. Only those patients in superior physical condition over 60 were accepted.

The psychiatric diagnosis is not of major consequence in the selection of patients. The essential point is that those syndromes caused by organic disease be excluded. Brain tumor, degenerative diseases of the brain, alcoholism, paresis and other infectious diseases of the brain must be excluded by clinical examination. The symptom constellation of: (1) tension, agitation and depression, (2) sleep disturbance, (3) somatic distress with a coated tongue and fetor oris almost constantly present is the primary indication for office ECT. Suffering from these symptoms to a degree that the patient insists that he will do anything to provide some measure of relief should be present. The presence or absence of delusions or hallucinations is not an essential element, and it is not too important if they are present or absent, provided they do not interfere with the patient's capacity to cooperate. The anxiety hysterias are not significantly helped by ECT, unless the constellation of the three groups of symptoms above is a prominent concurrent element.

The improvement in the patient's mood seems to bear a direct relationship to convulsions of moderate intensity, lasting for 20 seconds or longer. Sub-convulsive treatments and weak, short convulsions seem to have no real value. More recent apparatus are constructed with mechanisms termed "glissando" which permit the operator to eliminate the initial thrust of the convulsion and "slide" the patient into the firm tonic phase. This greatly reduces the chance of fracture and permits the development of the type of convulsion most effective. The use of intravenous barbiturates has virtually (1) eliminated post-shock excitement and (2) renders the patient anxiety free during the preparation of the treatment situation. It is not necessary to anesthetize the patient, hence, only enough Pentothal is used to accomplish these two aims. We have found that 3 or 4 grains of Pentothal produce enough relaxation to produce amnesia for the treatment.

No special preparation is necessary before treatment, except that patients abstain from food for three hours before reporting to the office. Treatment is given in street clothes, and the only ritual carried out is to remove false dentures or chewing gum before a mouth gag is introduced between the teeth. Pentothal is injected intravenously, and the patient rapidly goes to sleep. The head band is applied at this time, and, with the assistance of a nurse, the lateral sway of the patient is gently controlled by the nurse leaning across the patient while adducting both shoulders. The therapist manually turns the glissando at a moderate rate from 0 MA to 50 MA and swings back to 0 MA when the convulsion is established. The left hand is used to restrain a possible dislocation of the jaw. With the use of glissando, there has never been a case of post-convulsive apnea, and breathing begins within 15 or 30 seconds, if not during, the terminal phase of the convulsion. After termination of the convulsion, the patient is required to rest for 30 minutes before leaving the office with a relative or attendant. They are advised to go home, eat and then rest for two or three hours before resuming full activity.

Various muscle relaxants have been recently employed by many psychiatrists with the rationale that they reduce fracture probability. They are not without danger, however, and have introduced an additional hazard, which we feel is not suitable in the office situation. Almost every death reported from ECT showed that an additional procedure was employed besides the ECT itself. Deaths are extremely rare from ECT, considering the many tens of thousands

that are given in the United States every year. An occasional bizarre complication has been reported, such as, hemorrhage into the thyroid, cardiac arrest and actual damage to the brain. However, they are so rare that the incidence is scarcely greater than their spontaneous occurrence. In contrast, there is frequently the complication of fracture and dislocation.

The literature abounds with reports describing fractures of the long bones, hips, shoulders, jaws, etc. Compression fracture of the dorsal vertebra is very common, and before "glissando," occurred in as high as 20 per cent of treated cases. Although the incidence is decreasing with the new ECT machines, about 10 per cent of the patients complain of high back pain in which radiography may, or may not, show evidence of a small chip or stellate fracture. It has been proven that these fractures are of no clinical significance, and psychiatrists do not discontinue ECT because of their occurrence. The pain may last for several weeks after the last treatment or may disappear during subsequent treatments.

Fracture of a long bone or joint is a more serious matter and has occurred twice in the 2,511 treatments given in this series. The first case occurred in a 60-year-old man with a frozen right shoulder due to chronic bursitis and with a severe depression. After his first treatment, he complained of severe pain in his right shoulder. Fluoroscopic examination was reported as negative, and treatment was resumed. The pain became intolerable after his second treatment, and an X-ray showed a hairline fracture in the surgical neck of the humerus. The fracture healed, but ECT was not resumed. His mental condition remained unchanged after two years.

The second case occurred in a 38-year-old woman, who complained of pain in her left shoulder after her third or fourth treatment. X-ray examination was reported as showing a hairline epiphyseal separation. The surgeon felt that it did not preclude treatment, and 10 additional treatments were given. Pain disappeared during treatment, and her sling was dispensed with before concluding ECT.

Two deaths occurred concurrently with the administration of courses of ECT; one in a 70-year-old man with chronic coronary insufficiency and aortic stenosis. This man had received 8 treatments and was apparently well from the viewpoint of his depressive psychosis; however, two days following the last treatment, he died in his sleep. The second death occurred in a 55-year-old woman who was in the midst of a course of treatments, and during the intervals between treatments, awoke in the home and cried out to her sister that she was going to die. She is said to have thrown her arms over her head, developed the facies of terror and died within a few minutes. According to the family, two of her siblings died in an identical manner. No postmortem was obtained. The first case was known to be a poor risk, but was treated because of the insistence of the family and the family doctor. Several members of the family had died in mental institutions, and all preferred to assume any risks that offered the hope that he might remain at home.

The number of treatments required to effect a clearing of depressive symptoms is variable. In general, we give two treatments a week for 8 treatments, and then judge each case individually. About half of the patients need no additional treatments and remain well. In the other half, treatment is continued with a gradual lengthening of the treatment interval. About half of the remaining patients are in remission after 15 treatments. The others may require 20 to a total of 40 or more treatments to effect a satisfactory result. We do not consider less than 20 treatments enough to conclude that ECT will be ineffective. Improvement may occur after the first treatment, but it is seen more generally after the third or fourth. In those cases requiring more than 20 treatments, a heavy schizophrenic coloring is generally present, and many patients may be held in social re-

mission with treatments at widely spaced intervals. The patients vary in their capacity to carry on activities during the course of these treatments. This depends upon variable factors. We advise against driving a car at any time during a course of ECT and against participating in hazardous activities of any sort. Many patients continue at their jobs throughout treatment, however, as a precautionary measure we advise resting at home. Some patients decline to do this and continue to work at non-hazardous jobs or do housework, etc. At no time has a patient ever proven to be a menace to himself or others because of ECT effects received on an ambulatory basis.

The number of mild depressions and mild psychotic states that are seen in general practice far outnumber the cases that are seen in psychiatric hospitals. Most of these vehemently reject the idea of entering a psychiatric hospital, and their families concur in this prejudice. If their illness is protracted, and if economic loss is a hardship, or the degree of suffering is increasing, ECT should be considered.

The need for ECT has been reduced by the newer tranquilizing drugs, and many schizophrenic and occasional depressive states can be aborted, especially with Thorazine. The same drugs permit other patients to remain out of mental hospitals and enable them to cooperate to a degree to make possible a course of ECT on an ambulatory basis.

220 Baltimore Avenue
Cumberland, Maryland

RETROFLEXION AS A CAUSE OF DYSPAREUNIA

LEWIS BRINGS, M.D.

It is generally accepted that dyspareunia has psychological and emotional factors as underlying causes in a vast majority of patients. It cannot be denied, however, that in a small percentage of patients, definite physical factors are responsible. Dickinson and Beam[1] found that ten out of one hundred and seventy-five cases (6 per cent) had dyspareunia due to physical defects, such as infantilism or retroversion.

The effect of this condition on marriage is most unfortunate and will frequently lead to maladjustment and disruption.

This discussion is concerned with retrodisplacement of the uterus as the cause of dyspareunia; fourteen cases were operated between 1949–1952. In these patients, dyspareunia was considered to be caused by the retroverted uterus. Pelvic examination reveals a characteristic physical sign that is considered diagnostic. When the examining finger touches the corpus of the uterus through the posterior fornix, the patient obviously has marked discomfort. When the finger is gently advanced further towards the uterine fundus in the cul de sac, and the fundus is moved by the thrust of the finger, the patient is asked the leading question, "Is this the pain you have during marital relations?" If this question is answered in the affirmative and the retro-displacement cannot be corrected by conservative measures, surgical correction is advisable.

The method of suspension used is the Baldy Webster procedure.[2–3] A transverse abdominal incision is made below the hairline to enter the peritoneal cavity, thereby avoiding a visible scar and possible hernia formation on a young and active woman.

The fourteen patients herein reported were interviewed three years post-operatively by a tactful nurse who was well trained in psychology

TABLE 1

Completely Relieved			Improved			Not Improved		
Mrs. M. L.	Age 25	No children	Mrs. D. W.	Age 28	2 children	Mrs. L. T.	Age 21	1 child
Mrs. M. B.	Age 30	3 children	Mrs. H. A.	Age 27	1 child	Mrs. A. R.	Age 22	1 child
Mrs. H. A.	Age 30	3 children	Mrs. E. M.	Age 28	2 children	Mrs. M. H.	Age 20	1 child
Mrs. L. T.	Age 39	2 children						
Mrs. M. S.	Age 25	No children						
Mrs. P. B.	Age 23	2 children						
Mrs. M. G.	Age 37	3 children						
Mrs. J. C.	Age 32	2 children						

as well as handling gynecological problems.* The follow-up results are recorded on Table 1.

C. F. Fluhman,[4] in his article on retro-displacement operations, reports that suspensions are rarely done. Retro-position in itself is certainly not an indication for surgical interference, nor does every woman suffering from dyspareunia and having a retroverted uterus benefit by uterine suspension. Only when painful discomfort in the posterior fornix can be reproduced by touching and moving the retroverted uterus in the cul de sac, is the patient a promising prognostic prospect for surgical treatment. When examining these patients, it is necessary to avoid suggestive questioning and it is believed that the three failures among the operated cases are due to faulty pre-operative interrogation.

* I would like to thank Mrs. Marietta Early, R.N., Sacred Heart Hospital, Cumberland, Md., for her help in interviewing the patients.

SUMMARY

1. Dyspareunia, in a small percentage of cases, is due to physical causes.

2. Retroversion and flexion in some women may be the cause of dyspareunia.

3. The pain elicited during intercourse can be reproduced during pelvic examination. The contributing importance of uterine displacement of the case under study may be confirmed by the examiner.

4. The majority of these patients can be helped by surgical correction.

57 Greene Street
Cumberland, Maryland

1. DICKINSON, R. L. AND BEAM, L., A Thousand Marriages, Baltimore, 1931.
2. WEBSTER, J. C., Journal of the A.M.A., **37:** 913, 1901.
3. BALDY, J. M., The Journal of the A.M.A., **56:** 481, 1911. S. G. O., 1915, **20:** 361.
4. FLUHMAN, C. F., Bulletin of the Johns Hopkins Hospital, Vol. XCVI, 1955, Page 59.

TRAUMATIC DIAPHRAGMATIC RUPTURE WITH COMPLICATIONS

A Case Report

JAMES H. FEASTER, JR., M.D.,* AND JOSEPH ALVAREZ, M.D.*

In this our present day of speed, speed, and more speed, there is an ever increasing number of traumatic injuries seen in hospital emergency rooms throughout the nation. Apparently traumatic rupture of the diaphragm is increasing. It is sometimes overlooked because of other complicating injuries. However, it is imperative that we keep this possibility in mind whenever there is direct or indirect injury or violence to the upper abdomen or lower chest. Many times it is a life-saving procedure to recognize this injury, because an associated rupture of the spleen, left kidney or liver may have taken place and if these are not corrected immediately, death will ensue.

Many cases of traumatic rupture of the diaphragm go unrecognized and only later in life are they recognized and treated. These patients develop symptoms referable to the gastrointestinal tract from within a few weeks to as long as ten or twenty years after their initial injury. If, in the acute phase of the injury, treatment is not instituted, some of the following complications may arise: 1—Incarceration of bowel in the chest with obstruction. 2—Incarceration of the stomach within the chest with ulceration and perforation within as short a time as five to eight days. When one reviews the literature, it is noted that many of the hernias reported were not repaired immediately because they were not recognized. These unrecognized cases usually come to surgery at a later date and these are the people who apparently suffer the greatest disability. Early recognition and early surgical treatment should be the treatment of choice.

* Both authors are on the Staff of the Garrett County Memorial Hospital, Oakland, Maryland.

Traumatic diaphragmatic hernia is actually a misnomer, as there is no true peritoneal sac surrounding the contents of the hernia. Harrington's (1) definition, "evisceration of the abdominal organs into the pleural cavity," is preferred. The longer these eviscerated abdominal contents remain in the chest cavity the more difficult it is to replace them to their normal location.

Traumatic rupture of the diaphragm is most common on the left. In twenty-eight cases reported by Hughes (2) rupture occurred twenty-three times on the left and only five times on the right. The right lobe of the liver protects the right portion of the diaphragm while the left position is not as well protected, and hence more vulnerable to rupture.

Traumatic rupture of the left diaphragm is frequently associated with injuries to the spleen, liver and left kidney. Each of these organs may be involved alone or in combination with the others according to the direction and magnitude of the crushing force (3). Gerber (4) presented a case of traumatic rupture of the diaphragm, spleen and left kidney surgically repaired immediately and with full recovery of the patient. In our case, there was a traumatic rupture of the diaphragm, rupture of the spleen, rupture of the left lobe of the liver, and a contusion of the left kidney.

Johnston and Twente (5) reported an unusual manifestation of blunt trauma to the chest in which the patient sustained a crushing injury to the thorax and abdomen. This patient presented a traumatic diaphragmatic hernia with incarceration of the anterior surface of the fundus of the stomach above the left diaphragm. Perfo-

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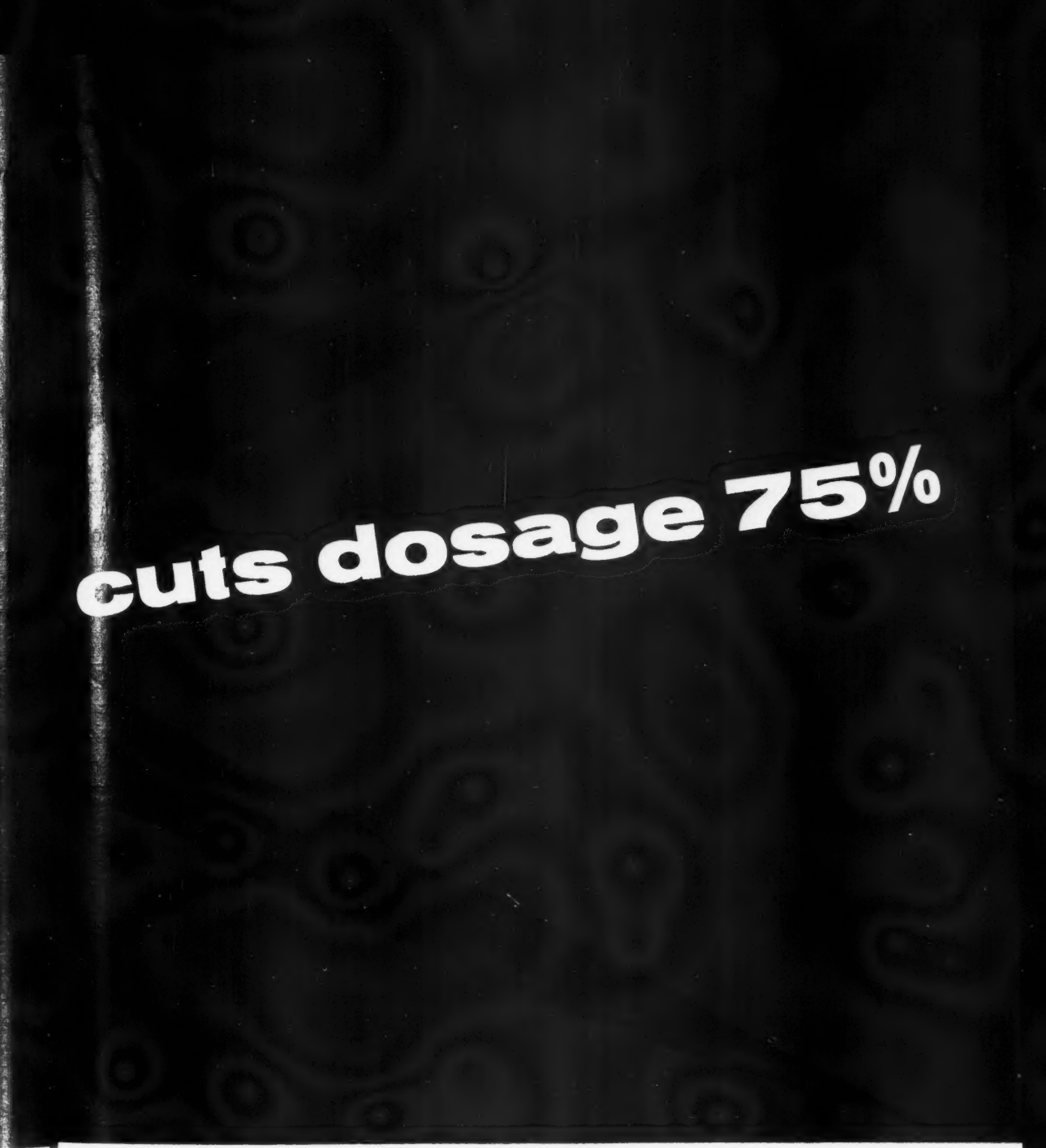

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ration of an acute peptic ulcer in the incarcerated stomach occurred on the fourth day after injury, resulting in a thoraco-gastric fistula, early empyema and death.

It would appear that the logical treatment of the injury is prompt surgical correction. For those cases allowed to progress without surgery, incarceration, strangulation and obstruction of bowel may take place as well as the development of ulceration and perforation. The important thing to remember is that a ruptured viscus must and should be repaired immediately. A ruptured spleen; a ruptured kidney; a ruptured stomach or a ruptured liver should certainly have immediate surgical repair as soon as the patient is out of shock.

Case Report

A thirty year old, white male, was admitted to the Garrett County Memorial Hospital approximately one hour following an auto accident. The left side of the patient's car had been crushed in, pinning the driver between the car door and the back seat, apparently with great force. There was some difficulty in extricating the patient from his auto. A very significant feature to us was that this patient had eaten a large meal approximately thirty minutes prior to the time of the accident.

Upon entering our emergency room the patient complained of pain in the left chest, left abdomen and left hip. He was unable to lie flat. Nasal oxygen, plasma substitutes and fluids were started immediately. Physical examination revealed the following:

A thirty year old white male, obviously having difficulty in breathing. Pulse 130. Blood pressure 70/40. He was perspiring profusely and was in obvious shock.

The head and neck regions were negative, except for superficial scalp lacerations over the temporal areas. Chest: There was dullness to percussion over the left lower chest. There were diminished breath sounds of the left lower chest and some crepitus over the left lateral chest wall. The apex beat of the heart was shifted to the right. The right lung was clear. Examination of the heart revealed tachycardia with a regular rhythm and no murmurs. The quality of the sounds were good. Abdomen: There were generalized rigidity and absence of the peristalsis. Genitalia: Negative. Rectal: Negative. Extremities: There was swelling, crepitus and pain on motion of the left hip and some pain below the left knee.

Laboratory findings: Hemoglobin at 2:30 P.M. shortly after admission was 87 per cent. Catheterized urine: one plus albumin; four plus sugar (Intravenous glucose); negative acetone; occasional white blood cell; red blood cells too numerous to count. At 7:00 P.M. the hgb. was 80 per cent and at 8:30 P.M., at the time of surgery, it was still 80 per cent.

X-ray examination of the left knee, left femur and chest upon admission revealed: (1) Communited and depressed fractures of the lateral left tibial tuberosity; (2) Intertrochanteric fracture of the left femur; (3) Fracture through the left ilio-pubic junction which involved the acetabulum; (4) Fracture of the left 7th and 8th ribs near the posterior axillary line; (5) Elevation of the left leaf of the diaphragm with free air above the level of the diaphragm. The mediastinum was shifted to the right.

The following tentative diagnosis was made:

(1) Traumatic rupture of the left diaphragm with abdominal contents in the left chest cavity.

(2) Possible rupture of the spleen.

(3) Fractures of the left 7th and 8th ribs, left hip, pelvis, left tibia and fibula.

(4) Surgical shock.

Prior to surgery, during and following surgery this patient received a total of 13 pints of blood. After his condition became stabilized, he was taken to the operating room.

Under endotracheal nitrous oxide-oxygen-ether anesthesia, the chest was entered through the 6th left interspace. The incision was extended through the costal margin onto the left rectus muscle. The chest was found to contain almost

the entire stomach, and the detached portion of the left lobe of the liver, as well as some jejunum, colon and omentum. These abdominal organs entered the chest through a rent in the diaphragm laterally. The traumatic rupture was approximately 15 centimeters in length. There was no rupture of the intestine or stomach, but the spleen was found to have multiple areas of contusion and linear ruptures with bleeding. The left lobe of the liver was torn and a piece of liver approximately 2 x 4 x 6 centimeters was almost completely avulsed. The torn edge of the liver was repaired, a splenectomy was performed and the left kidney completely exposed. It was contused and edematous, but the capsule was not ruptured. Phrenic crush was performed. The diaphragm was repaired by imbrication with interrupted sutures of fine cotton. There was considerable trauma to the lateral chest wall, causing a generalized oozing of blood. The chest was drained through a #32 rectal tube which was brought out through the 8th intercostal space laterally. The abdomen was drained with a penrose drain which was brought out through a lateral abdominal stab wound. The abdominal drain was used because the tail of the pancreas was traumatized slightly and because of generalized oozing. The incision was closed in layers. The costal cartilages were approximated with #32 stainless steel wire sutures. At completion of the operation, the lung was partially re-expanded and the rectal tube from the chest wall was attached to an underwater seal.

Following surgery, the patient had a fairly stormy course. He was treated with oxygen; antibiotics; intestinal intubation, and intravenous fluids. A pleural effusion developed after the drainage catheter was removed on the third day. He was treated by paracentesis on 3 separate occasions. A massive atelectasis was treated by tracheal aspiration with a urethral catheter. By July 10th the patient's chest was completely clear.

During this time the patient developed a relative oliguria and azotemia. There was a progressive rise in his blood-urea nitrogen with a maximum (125 mgm. per cent) occurring about 10 days to two weeks following admission. A spontaneous diuresis then took place with gradual improvement in the blood-urea nitrogen determinations. We attributed this to a mild lower nephron nephrosis, on the basis of extensive trauma and shock.

On July 10th the patient's left hip was pinned and ten days later the fractures of the left knee were repaired by open reduction under spinal anesthesia. The patient was discharged from our hospital on August 1st in good condition.

This case is presented primarily to show what can be done in a small hospital where the staff is well organized and where the laboratory and X-ray departments work hand in hand with the doctors. It also demonstrates the absolute necessity of immediate surgery for this type of injury. Delay would have meant death.

SUMMARY

A case of traumatic rupture of the diaphragm, with a concomitant ruptured spleen; ruptured left lobe of the liver; traumatized left kidney and displacement of the stomach transverse colon, jejunum and greater omentum into the left chest cavity, is presented. A successful surgical repair was carried out with complete recovery of the patient.

Garrett County Memorial Hospital
Oakland, Maryland

BIBLIOGRAPHY

1. HARRINGTON, S. W., Diaphragmatic hernia. Cyclopedia of Medicine, Surg., Specialties, 1950, F. A. Davis Co., Philadelphia. Vol. 4: p. 585.
2. HUGHES, F., KAY, E. B., MEADE, R. H., JR., HUDSON, T. R., AND JOHNSON, J., Traumatic diaphragmatic hernia. J. Thoracic., **17:** 98, 1948.
3. ADAMS, T. W. AND MUSSELMAN, M. M., Recognition and arrangement of the triad of injury to the spleen, kidney and diaphragm. A. M. and Surgery, 1954 **87:** 452–4–56, March, 1954.
4. GERBER, M. L., Repair of traumatic diaphragmatic hernia. U. S. Armed Forces M. J., **1:** 1413–1417, December, 1950.
5. JOHNSTON, J. H., JR. AND TWENTE, G. E., Perforated gastric ulcer in acute diaphragmatic hernia. Surgery, **31:** 742–752, May, 1952.

RELIEF OF PAIN IN OBSTETRICS

W. ROYCE HODGES, M.D., F.A.C.S.

In the fifteen years since Hingson and Edwards reported their thirty-three cases of labor managed with continuous caudal analgesia, there have been literally reams written in favor and against this form of pain relief. As one who became interested in obstetrics because of continuous caudal, I am naturally interested in its present value in relation to other methods.

One may think of pain relief as a spectrum. At one end we have psychoanalgesia or "natural childbirth,"—at the other end, continuous caudal analgesia. Both, at their best are ideal. The one, despite training classes, etc., depends chiefly upon the patient for success; the other, entirely upon the judgment and skill of the physician. Anyone who has witnessed a successful "natural childbirth" must admit that it is the best for mother, baby, and the attendants. There is no more satisfying picture in all of medicine. These "bests" however are few and far between. They depend, to my way of thinking, too much on the patient's background—and it is a little hard to pick one's parents, not to mention the grandparents.

Take a look at the other end of the spectrum. Continuous caudal analgesia demands the judgment to know the proper time it should be given and to which patient. I can give no rule of thumb. In general, one would wish the patient to be intelligent and cooperative and equipped with a reasonably palpable sacral hiatus. If she is a victim of severe "needlephobia," then avoid caudal as the devil does Holy Water—otherwise all her subsequent ills and imaginary ills will stem from "that needle."

When electing to employ caudal analgesia, consider that, as a rule, two to three hours is about the longest time anyone wants to be in one position, even with complete relief of pain.

The two important points with this method are, first: be as certain as you can, that in your hands the method will be successful for each individual on whom you choose to use it. For once you are committed to caudal analgesia, it had *better* work. Second, and this requires the greatest judgment, be sure that the circumstances in the given patient are such that caudal will not interfere with her labor. Such assurance can only come after many errors in judgment. As has been said, "Caudal at its best is unbeatable, but————."

Immediately adjacent to continuous caudal in the spectrum, we have low spinal anesthesia or, as it is named for the public's benefit, "saddle block." Here the advantages and disadvantages are quite obvious. Ease of administration and immediate relief, coupled with no depressing effect on the baby are on the positive side. On the negative side of the ledger, there is the occasional, but severe unpredictable postlumbar puncture headache (which is certainly decreased to a minimum by skillful technique and employment of as small a needle as practicable). Although single injection spinal anesthesia can be expected to give relief for an hour or more with the customary low dosage, this method is essentially an anesthetic for delivery rather than an analgesia for labor and delivery. With both caudal and spinal anesthesia, we are constantly faced with the absolute need for asepsis and antisepsis. The only sure way to obtain this, is autoclave sterilization of all solutions, needles, and tubing employed.

Successful employment of the above outlined methods result in complete pain relief, safety for both mother and baby, and ideal patient control. (It would be interesting to watch a general surgeon attempt to work in the operating room under the conditions, which are frequently prevalent in labor and delivery rooms, when

the usual methods for pain relief are employed.)

These usual methods just mentioned are not to be condemned. They include the various forms of preanesthetic medication such as demerol, with or without scopolamine and more recently with or without thorazine or phenergan. These preliminary drugs are always useful if they are somewhat unpredictable. Care must be taken to avoid overdosage, because of the baby; even though some infants are notorious in their ability to withstand large doses shortly before birth.

At this juncture, a word may be said regarding the barbiturates; if they are to be used, I would prefer to use them intravenously, and the preparation with which I have had the most experience and success is intravenous nembutal used in a solution of 50 mgm. per cc. The maximum amount that I have employed is 5 cc., given slowly until the desired sedative effect on the mother is obtained. Its action is much more predictable when given intravenously, and there have been no instances of overly sedated babies from patients in whom I have used this preparation.

A word about depressed new-born infants. When conduction techniques have been employed, with the usual amount of preanesthetic sedation, there have been no problems at any time. When preanesthetic drugs have been used in combination with general anesthesia, we occasionally have some babies which are very depressed. We have been greatly impressed with the beneficial effects of rocking these infants after careful clearing of their air passages by gentle suction. These infants when placed in the rockette, and rocked, begin to "pink-up" in a few minutes and often will do so before any attempts at spontaneous respiration. This offers the added advantage of protecting the baby from injudicious mishandling.

As for the general anesthetics frequently employed, nitrous oxide and oxygen, ether, either by the open method or through a machine combined with oxygen, and trilene are the most popular. They are simple to give, and give generally satisfactory relief to the patient providing she has had no experience with more effective methods. They are frequently supplemented by local perineal infiltration or pudendal block. Both these latter are quite satisfactory for relief of perineal pain, but of course have no bearing at all on the real pains of labor. I have had no experience with hypnosis, or the recently reported combinations of cyclopropane, nitrous oxide, and oxygen.

In reference to general anesthetics, our experience with pentothal sodium as an anesthetic for cesarean section, has been most satisfactory. It should only be employed by a competent anesthetist accustomed to working with an operative team, who realize the time limitations from onset of the pentothal anesthesia until the actual delivery of the baby. (This time should not exceed five minutes although theoretically longer periods are allowed.)

Institutions that are fortunate in having qualified physician-anesthetists, experienced in spinal or epidural anesthesia will frequently prefer these as the method of choice in cesarean section, both from the standpoint of the baby and mother.

Our experience with continuous caudal anesthesia covers 2,183 deliveries under this method, out of a total of more than 5,000 deliveries in the past fifteen years. There have been no maternal deaths due to any form of anesthesia in this group of patients.

Summary

A period of more than fifteen years of fairly extensive experience with conduction and general anesthesia in obstetrics has lead us to the following conclusions:

1. When possible, and this has been infrequent in our hands, natural childbirth is the ideal method when it can be satisfactorily worked out, between the patient and her physician.

(In our experience, the patient is by all odds the most important factor in the success of this method.)

2. Except in those patients who are psychologically opposed to any form of "needle technique," and those in which there are anatomical abnormalities of the sacrum, and in those which the character of the labor may rule out conduction analgesia as a method of choice, we prefer continuous caudal for analgesia and delivery or low spinal for anesthesia during the actual delivery of the child.

3. There is a large group of patients, in the majority of instances, far outnumbering the above mentioned, in which for practical and psychological reasons, some form of general analgesia and anesthesia must be employed.

As has been frequently pointed out by many authors, the average baby will do well with any form of analgesia and anesthesia properly administered. However, the borderline cases including some prematures and many full term babies after a long hard labor, can usually be better protected from anoxia by the employment of some form of conduction anesthesia during at least the last hour or two of labor or delivery.

122 South Centre Street
Cumberland, Maryland

THE MANAGEMENT OF EMPHYSEMA

R. W. BALLIN, M.D.

The middle aged patient with emphysema constitutes a difficult problem to the practicing physician, and it is no wonder that many of us adopt a rather defeatist attitude toward the condition and feel that not much can be done about it anyway. However, even though these people cannot be restored to normal, almost all of them can be improved. Furthermore, since the condition is difficult to treat, everything we can do to prevent it, is worthwhile.

The textbooks usually make a distinction between obstructive and degenerative emphysema. Actually by far the most cases which the practitioner sees, are of a mixed type and, to make matters more complicated, a number of extrapulmonary factors tend to aggravate the situation. The emphysematic is largely a respiratory invalid and in order to rationalize his treatment, it is necessary to keep in mind all the factors which decrease his respiratory efficiency.

We are familiar with the microscopic picture of the emphysematic lung. Most striking is the fact that many alveoli have ruptured into each other and that instead of many small air sacks, we now have large bullae. This of course, diminishes the total effective surface on which the gaseous exchange between blood and air can take place. In the interstitial spaces we find sclerosing and obliteration of the blood vessels, which of course interferes with the blood supply. Fibrosis and thickening of the alveolar membranes creates a barrier between the blood and air spaces. There is also a varying degree of destruction of the elastic fibres which normally are responsible for the expiratory phase of the air exchange. This, then interferes with the movement of air in and out of the alveoli. In the bronchi and bronchioli, we find inflammatory changes which are responsible for the production of bronchial secretions. The presence of these secretions together with swelling of the mucous membrane lining of the bronchi, causes obstruction, and since the bronchi dilate slightly during inspiration and collapse again during expiration; a valve mechanism is created which will allow air to enter the peripheral air spaces, but will not allow it to escape; thus creating the phenomenon of air trapping. The chronic inflamma-

tion of the bronchi gradually destroys the ciliary epithelium, which normally lines the bronchial tree and which constitutes an important part of the lung cleansing mechanism. The presence of the bronchial inflammation and the secretion creates a steady, irritative cough, which intermittently causes sudden increases in the intra-alveolar pressure; which in turn causes more and more alveoli to rupture. Thus, more and more of the effective alveoli are lost and transformed into ineffective blebs. The sclerotic changes in the branches of the pulmonary artery are responsible for the pulmonary arterial hypertension which develops and which ultimately leads to right heart strain and cor pulmonale.

Fluoroscopic examination of the chest, shows the diaphragm to be depressed and showing only about twenty per cent or less, of normal motion. Since diaphragmatic motion according to studies following interruption of the phrenic nerve accounts for twenty-five per cent of the pulmonary efficiency of each lung, it is obvious that this reduced function seriously interferes with proper ventilation.

Frequently, other conditions which aggravate the respiratory insufficiency are found in the same patient. Osteo-arthritic changes in the thoracic cage interfere with the proper movement of the ribs. Hypertensive and arteriosclerotic heart disease may be present, and often an allergic bronchitis complicates the picture. Post-nasal drip from an allergic or infectious sinusitis, may continue to irritate the bronchial tree. In advanced and severe cases, there may be forward failure due to cor pulmonale or backward failure, due to arteriosclerotic changes in the left ventricle.

Numerous theories have been advanced concerning the etiology of emphysema. It is generally agreed that it is a degenerative condition, similar to arteriosclerosis and atherosclerosis, which of course plays an important role in its genesis. There appears to be a familial tendency to the development of emphysema and the opinion is frequently expressed, that there seem to be families in which pulmonary conditions are prevalent. It is not unusual to find families with large numbers of siblings, in which a few have chronic bronchitis; several have bronchiectasis, one has tuberculosis, one has asthma, some have varying degrees of emphysema and finally one of them is found to have developed a carcinoma of the lung. Physicians working in tuberculosis hospitals, are often impressed with the fact that the visiting relatives of the patients cough more, than the patients themselves.

In view of the fact, that emphysema is so difficult to treat, everything possible should be done to prevent the development of the condition. The potential candidates for the development of emphysema, are comparatively easy to spot. They are young people who come from "pulmonary families," have frequent attacks of vaso-motor rhinitis, respiratory infections and seem to have great difficulty in "shaking their colds." Physical examination usually shows already a slight suppression of the breath sounds, over the bases of the lungs and fluoroscopy reveals a depressed diaphragm, which moves comparatively little during respiration. It is these people, who should be advised not to treat their own colds and to seek immediate medical aid for any cough, which they can't stop within a few days. Every prolonged cough, will destroy a few more alveoli and over a period of time, the diminishing amount of effective respiratory surface will become critical. Sinus conditions, allergic or otherwise, in these people should be intensively treated and they should be thoroughly indoctrinated with the fact, that a non-productive cough is useless and harmful. Most of these potential emphysema victims, would be better off if they would not smoke, even though this piece of advice is usually not followed, until rather severe symptoms have developed. The physician's own attitude toward smoking, has a lot to do with his success in convincing his patients of the necessity of avoiding this form of bronchial irritation.

As far as treatment of the full blown condition

is concerned, it is usually very gratifying to see how much better the patient feels, after the bronchial tree has been "cleaned up." It is characteristic of these people, that they have their worst time early in the morning and that they begin to feel better, after they have emptied their bronchial tubes. A combination of expectorants with small doses of Ephedrine and Codeine, often brings some immediate relief. In many people, it is necessary to add a small dose of phenobarbital, to prevent development of a tachycardia from ephedrine. Antibiotics are of great value and are best used after sensitivity studies of the sputum are done. Any Health Department laboratory in this state, will accept these sputum specimens and will render a report as to which antibiotic is most likely to control the bacterial flora encountered. In severe emphysematics, it is often advantageous to continue the administration of antibiotics over a long period of time, similar to the rheumatic fever prophylaxis. Breathing exercises are easy to use. It is best to teach the patient to push out his lower abdomen, while he is lying on the examining table, with his own hand on his stomach. He will later learn to do this in most any position and the exercises will at least in part, restore the motion of the diaphragm. The use of Isuprel in a #40 Devilbiss nebulizer, several times a day, will often help a patient to get rid of some of the secretions which interfere with his breathing. In cases with severe suppurative bronchitis, bronchoscopic aspiration and lavage may give considerable relief. Of course, anything that can be done to improve the patients general condition, should be done. Obesity, which contributes to the dyspnea, will have to be corrected; arthritic changes in the thoracic cage may require treatment and allergic conditions of the sinuses and bronchial tubes, should be controlled.

In the later stages of the condition, when cardiac complications develop, digitalis and mercurial diuretics are indicated, even though it is well known that these measures are not as successful in emphysematics, as they are in those patients who are suffering from heart disease only.

All the measures enumerated thus far, are well within the reach of the practitioner. The large medical centers, in addition to these, use measures which require fairly elaborate apparatus. Intermittent positive pressure with or without bronchodilators and antibiotics and mechanical exsufflators, are employed. These treatments are effective only, if they are employed several times a day for prolonged periods of time and are frequently beyond the reach of the average patient and his physician.

Abdominal belts to elevate the diaphragm have been recommended, but have little value. Therapeutic pneumoperitoneum, even though it has its ardent advocates, has not gained widespread acceptance, even though the apparatus for its administration is still widely available and in most instances, standing idle, since this type of treatment has been largely abandoned in the management of tuberculosis.

Hinshaw and Garland, in their recent book on "Disease of the Chest," state that "breathing is the most primitive and urgent human need, and when conscious effort is required to satisfy this hunger, violent emotional forces may appear. Therefore, when breathing becomes difficult, the patient promptly seeks the advice of his physician and a satisfactory diagnosis is required, as well as relief." In our emphysematics, prevention without any doubt, is better than treatment; but regardless, he can always be improved if we have the necessary enthusiasm and skill.

62 Greene Street
Cumberland, Maryland

STENOSIS OF URETERAL MEATI

HOWARD L. TOLSON, M.D.

Abnormally small ureteral meati constitute a frequent and important pathological situation in the urinary tract. The ureteral terminals are one of three normal points of diminished caliber. If during embryonic life the terminals fail to acquire normal caliber, the meatus is too tiny for proper drainage and the ureter above may dilate with the intravesical portion forming a cyst-like structure termed ureterocele. In less marked degrees, the ureteral folds are prominent, elevated and elongated with pin-point size orifices. Although stenosis of ureteral meati is congenital, sufficient accommodation to the condition may occur during infancy, childhood and early adult life to prevent the production of symptoms and its recognition. It appears that stenosed ureteral meati tend to become smaller as the individual grows older. Usually the stenosis is bilateral and both sexes appear to be equally involved. In males, stenosis of the urethral meatus often accompanied stenosis of the ureteral meati. Impaired renal drainage consequent to stenosis is an important factor in the etiology of pyelonephritis and renal calculi.

Etiology

The failure of ureteral meati to acquire adequate, normal size during intrauterine life is the conceded cause of most cases. In some instances, however, stenosis is acquired by a process of cicatricial narrowing of the orifices during chronic inflammation, as renal tuberculosis; and neoplasm involving the trigone.

Symptoms

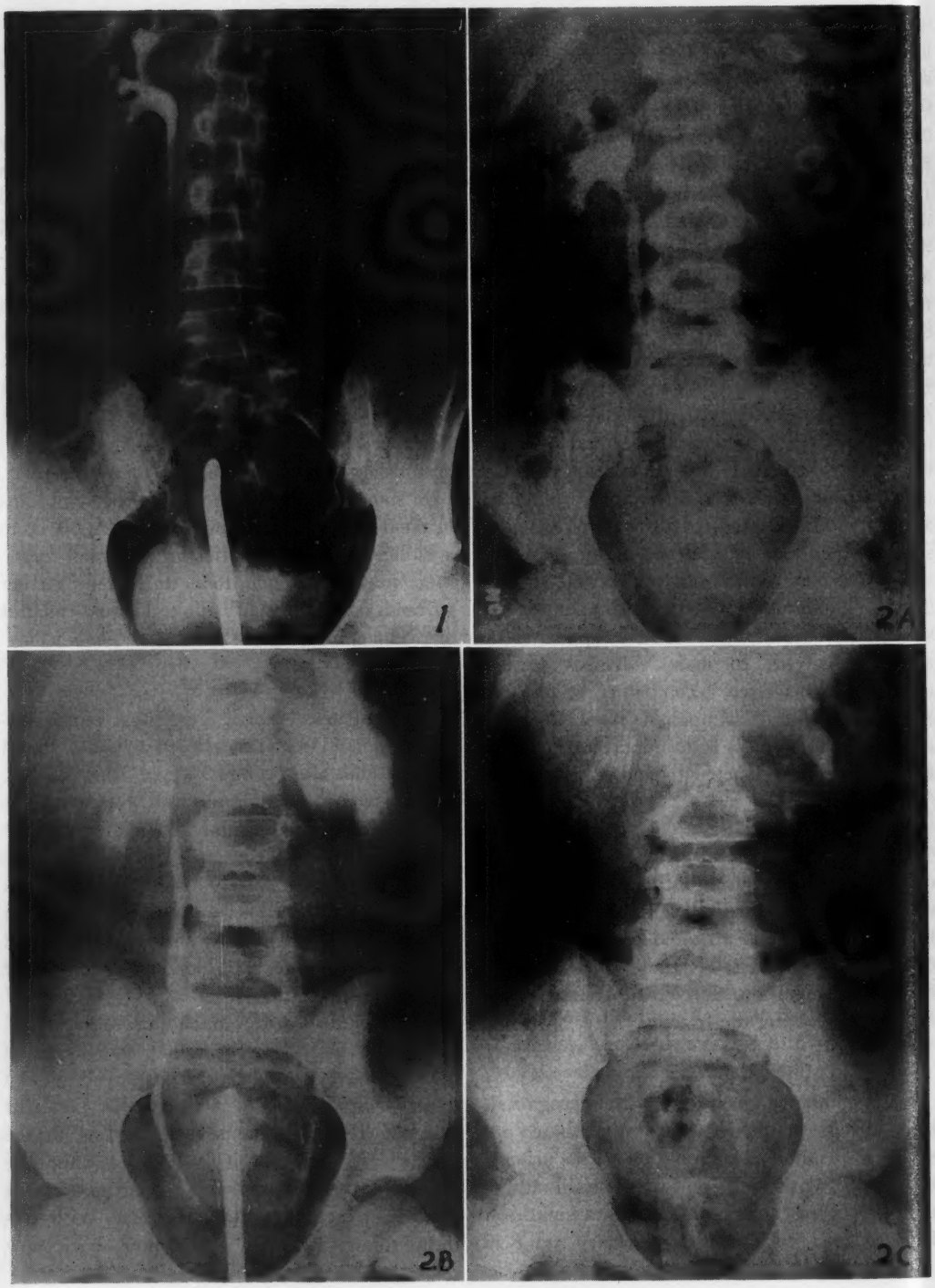
During infancy, few cases are recognized, but during childhood frequently there are symptoms leading to examinations of the urinary tract. Persistent or recurrent pyuria is an indication for cystoscopic and x-ray examinations. Pain referred to the upper urinary tract is another symptom in young patients. Pain may begin acutely, suggesting that ureteral edema has produced further blockage and spastic ureteral contractions. Other patients have recurrent aching pain in lumbar back or lower quadrants. Another group has chiefly gastroenteric disturbances: gas distention, belching, anorexia and constipation. Chronic renal overdistention disturbs the gastrointestinal innervation. Continuous renal overdistention is one of the causes of hypertension. Hematuria of renal origin is at times produced by persistent renal overfilling; one of the causes of so-called essential hematuria.

In short, one or any number of the symptoms of renal overdistention may be present. If there is sufficient accommodation to the small meati, there may be no symptoms until some further pathology in the urinary tract, as renal calculus or pyelonephritis occurs.

Diagnosis

The diagnosis is made by cystoscopic examination. Small circular meati situated on elevated ureteral folds are a common type. Other stenotic meati have a normal appearance except for the minute size. Indigocarmine given intravenously is a distinct aid in the recognition of the tiny orifices. One can not rely upon the information secured by intravenous pyelography to make the diagnosis, but the information furnished may be suggestive and indicate the need for further investigation.

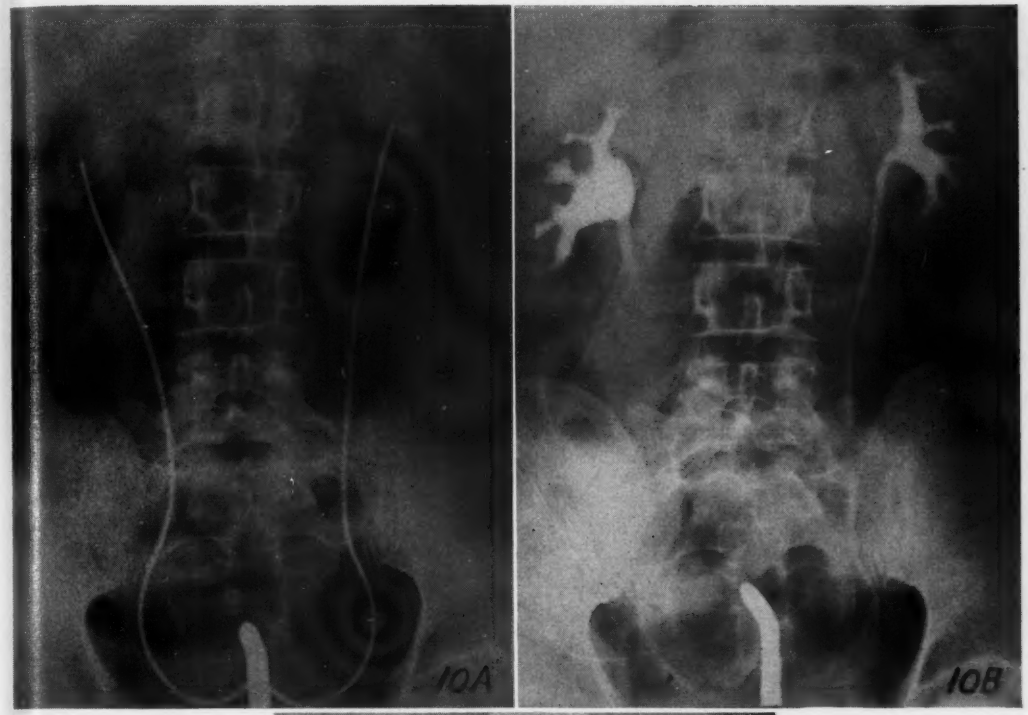
In order to secure maximum radiographic information regarding the kidney and the entire ureter, I have for some years employed gravity filling with an opaque solution—15 per cent skiodan. This solution is not irritating to the urinary tract, and if it is instilled while the ureteral catheter is removed, the entire ureter is filled in a high percentage of cases. With this technique rarely does pyelovenous back flow



FIGS. 1, 2A, 2B and 2C—See page 208 for legends

FIGS. 3, 4, 5 and 6—See pages 208 and 209 for legends

FIGS. 7, 8, 9A and 9B—See page 209 for legends



FIGS. 10A, 10B and 11—See page 209 for legends

FIGS. 12A and 12B—See page 209 for legends

FIG. 1. D-3647, Mrs. S. L., Age 26, 1–20–56. Pyeloureterogram made by gravity method using sufficient 15 per cent solution Skiodan to fill the kidney, pelvis, calices, and ureter, without overfilling and without the pain that often occurs with syringe filling. There is no pyelovenous back flow and the excessive Skiodan solution appears in the bladder. The ureteral catheter has been removed for more accurate demonstration of the ureter. Kidney, pelvis, calices and ureter are considered normal.

FIG. 2A. C. H. 4895, 9812 C4832 12–9–54. Five year old female child admitted to Memorial Hospital, Cumberland, with the third attack of pyelonephritis during the past year. Intravenous 30 minute film shows marked impairment of drainage from both kidneys. Cystoscopic examination disclosed stenosis of both ureteral meati.

FIG. 2B. C. H. 12–13–54. Retrograde gravity pyelography reveals bilateral hydronephrotic changes.

FIG. 2C. C. H., Intravenous pyelography, 8–20–56. Both ureters have been dilated to 13 F. Infection has been eliminated. Both kidneys are functioning and draining satisfactorily. The pelves and calices have decreased in size since the first examination.

FIG. 3. D-379, C. A. 9–19–55. Female child 10 years old admitted to Memorial Hospital with severe pain in right abdomen and right kidney area, nausea and vomiting. Eight minute intravenous film showing impaired drainage of right kidney—moderate degree right ureterectasis. Cystoscopic examination revealed bilateral stenosis ureteral meati, prominent ureteral folds with edema right ureteral fold. Relieved by ureteral dilatation.

FIG. 4. 3327 M. S., Age 12, 6–10–53. Admitted to Memorial Hospital with history of nephritis beginning six years previously, continuing albuminuria and casts. Blood pressure 96/66. Cystoscopic examination revealed minute pin-point type ureteral meati. Number 5 F catheters were tight in terminal portions of ureters. Both ureters were dilated to 9 F through 22 F cystoscope. Following discharge from the hospital he was seen in the office. Usually small amounts of albumin were present. Blood pressure increased. 2–23–55—165/105, 9–2–55—182/118, 9–23–55—205/125. 9–26–55—hospitalized 230/160. Blood urea 40, blood urea N 18, urine clear, albumin 100 mgms. Both ureters were dilated to 11 F. Intravenous pyelography not significant except that no film had sufficient concentration of pyelographic material to render a satisfactory picture. The five minute film indicates some impairment of renal drainage. 3–21–56—164/122—albumin 1 plus, urea 68—urea N .31. 7–12–56—hospitalized 216/142—both ureters dilated to 13 F. 9–14–56 no complaints. Urine has faint trace albumin, blood pressure 164/98.

FIG. 5. D3678 D. D., Age 16, 1–20–56. Three attacks severe left renal colic during past year, requiring hypodermics. X-ray film revealed no calculus shadow. Pyelography revealed caliectasis, pyelectasis, upper ureterectasis and exaggerated small terminal caliber. Cystoscopic examination revealed stenotic meati with edema of left ureteral fold. She has been entirely relieved by ureteral dilatation.

FIG. 6. B18, C. S., Age 26, 12–30–52. Complaining of severe right renal colic which has required three hypodermics. X-ray examination revealed no calculus shadow. Intravenous pyelography was unsatisfactory. Cystoscopic examination revealed stenotic meati and edema of right ureteral fold. Pyelography revealed right caliectasis, pyelectasis and ureterectasis. The ureter is elongated and has a non-obstructive kink. He was entirely relieved by bilateral ureteral dilatation.

FIG. 7. D-3359 Mrs. D. Y. Age 33, 1–10–56. Attacks of right renal colic. X-ray examination revealed no shadow of calculus, but there are shadows of calcified mesenteric lymph nodes on right side of abdomen. Pyelography revealed slight bilateral pyelectasis. Cystoscopy revealed stenosis of both ureteral meati. She has been relieved by gradual dilatation of the ureters to 14 F.

FIG. 8. C9727 Mrs. L. R. Age 33, 6–13–55. Admitted to Memorial Hospital complaining of attacks of severe right renal colic, nausea and vomiting. Has eight children. Right kidney palpable and tender. X-ray examination revealed no calculus shadow. Right pyeloureterogram reveals moderate pyelectasis, marked ureterectasis with tortuosity and elongation. Cystoscopic examination revealed ureteral meati of small pinpoint type. She has been entirely relieved by gradual ureteral dilatation to 14 F.

FIG. 9A. B821 Mrs. E. B. Age 28, 2–11–53. Complaining of severe right renal colic which has required three hypodermics. X-ray examination revealed a 5 mm. calculus shadow in lower calyx. Cystoscopy revealed stenotic meati.

FIG. 9B. B821 Mrs. E. B. Right pyelography revealed caliectasis, pyelectasis and ureterectasis. The ureter is elongated and has a non-obstructive double kink. Relief was complete following bilateral ureteral dilatation. The calculus passed spontaneously, and it was recovered following the third treatment.

FIG. 10A. 14123 Mr. F. C. Age 36, 1–16–50. Left renal colic was chief complaint. X-ray examination revealed calculus in left renal pelvis.

FIG. 10B. Mr. F. C., 1–16–50. Cystoscopy and pyelography revealed—Stenotic meati, right caliectasis and pyelectasis. He was relieved by left pyelolithotomy and bilateral ureteral dilatation.

FIG. 11. 9937 Mr. R. S. Age 41, 4–25–54. Complaining of attacks of pain in each kidney area and each lower quadrant, at times simultaneously. Cystoscopic examination revealed stenotic meati. X-ray examination revealed no calculus. Pyelography showed slight bilateral pyelectasis and caliectasis. Note impression of left renal vessel at ureteropelvic juncture and complete filling of ureters with the radiographic solution. The general health has improved and he has been relieved following ureteral dilatation on six occasions.

FIG. 12A. B578 and B621, Mrs. C. W. Age 26, 1–29–53. Hematuria, pain in back and daily headache were the chief complaints. A smooth mass was felt in left abdomen. Cystoscopy revealed abnormally small ureteral meati. X-ray examination showed a few small calculi in the large left hydronephrotic kidney, which excreted only a faint trace of indigocarmine in a half hour. The right kidney pelvis and calices are slightly dilated. Note displacement of left ureter by hydronephrotic mass. Indigocarmine excretion from the right indicated satisfactory function.

FIG. 12B. B621 Mrs. C. W. 1–29–53. By aspiration 375 c.c. clear fluid was removed from left kidney and 225 c.c. Skiodan solution was used to make the pyelogram. The patient was relieved by dilatation of right ureter and left nephrectomy.

occur and the pelvis, calices, minor calices and entire ureter are filled. The filling is without pain. Almost never does sudden severe renal pain of overdistention occur when the gravity method is employed. It is a technique of making pyeloureterograms with complete filling and without overfilling. Safety, comfort, and complete information are the features offered by gravity filling of the upper urinary tract. Bilateral simultaneous pyelography is entirely safe when indicated. I am deeply indebted to Doctor William N. Taylor, Chief of Urology, University Hospital, Columbus, Ohio, for his kindness in pointing out the advantages of the gravity method.

TREATMENT

In most instances, gradual dilatation of ureters with bougies is the method of choice. There is minimal trauma and the results are more lasting when the dilatation is not overdone at one sitting and when the intervals between treatments are long enough to permit mucosal edema to subside (three to four weeks). In most cases, the dilatation is begun with small olive tip bougies. Often a number 6 F catheter will not pass until a small bougie has passed. After a number 8 bougie has passed, the further dilatation is carried on with Garceau tapered bougies. In general, it may be stated that if the ureteral caliber is brought to a sufficient size, the results are satisfactory.

In some instances, I have employed diathermy cutting current to incise stenotic meati. This procedure is followed by bougie dilatations at three to four week intervals. It is my impression that more cicatricial fibrosis at the ureteral terminals results from this form of treatment than with dilatation alone.

Edema of Ureteral Mucosa

In spite of utmost gentleness in the passage of catheters and bougies through stenotic meati, some degree of mucosal edema, usually slight, follows the initial examination. If both stenotic meati are dilated at the time of the first examination, edema of terminal ureteral mucosa may be sufficient to temporarily obstruct the ureters with resulting anuria. To diminish the incidence of this complication, it is prudent to dilate one ureter only at the time of the first examination. If anuria does follow cautious instrumentation, the insertion of an inlying ureteral catheter may be necessary. In only one instance in my experience has nephrostomy been necessary to relieve anuria due to edema of ureteral mucosa and stenotic meati.

Summary

Stricture or abnormally small caliber may occur at any point in the ureters. The terminal openings are a common site and usually the term stenosis is employed.

Without proper correction it is the forerunner of other pathological changes in the upper urinary tract. The effects of inadequate renal drainage may be reflected in the circulatory system, and in the gastro-intestinal tract. The condition is readily recognized by cystoscopic examination. Adequate gradual dilatation provides relief in most instances. Stenosis should be recognized and adequately treated before the subsequent pathological changes in the upper urinary tract occur.

To present some of the roentgenographic findings in patients with stenotic ureteral meati the films of eleven cases in both sexes at various age levels are herewith reproduced. The reader is requested to keep in mind that the retrograde pyelography was by the gravity method. A reproduction of a pyeloureterogram depicting an adult normal kidney with normal pelvis, calices, and ureter is included. Also, some reproductions of intravenous pyeloureterograms are included.

POSTGRADUATE COURSE IN ELECTROCARDIOGRAPHY

A postgraduate course in Electrocardiography, designed to be digestible for beginners and also valuable as a refresher course for those who already have a working knowledge of the subject, will be presented at Mercy Hospital, June 10 to June 14, 1957.

FACULTY

Coordinator:	Dr. Henry J. L. Marriott
Guest Speakers:	Dr. Robert P. Grant
	Dr. William R. Milnor
	Dr. Leonard Scherlis

Three work-shop sessions will be devoted to practice in interpretation and a prize will be awarded to the registrant achieving the highest score during these sessions. Registrants will be guests of Mercy Hospital at a dinner on June 12. Closing date for registration, May 27.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.
Journal Representative

Dr. Charles Llewellyn Owens

Dr. Charles L. Owens, now retired, began practice in Cumberland, Allegany County, in 1904. Charley grew up on a farm in Baltimore County, attended Franklin High School, in Baltimore and St. John's College, Annapolis. From there, he went to the University of Maryland Medical School, graduating in 1904.

For fifteen years, he did general practice in South Cumberland, living on Virginia Avenue and Park Street, uptown. In 1919, he limited his practice to obstetrics and spent sometime in New York Lying-In Hospital, with practice on the St. John's Guild Harbor Boat, which anchored at various locations around Manhattan Island, in the Hudson River.

Delivering babies and teaching sanitation to the settlements, caused him to get an offer from the New York Board of Health, to become a permanent employee of the City of New York, but he preferred to return to Cumberland, where he was one of the best, if not the best known obstetrician in Western Maryland and limited his practice to that speciality.

After a year in Cumberland as a young physician, he had accomplished little and was prepared to leave and settle in Mt. Savage, a thriving village where the first iron rails in the world were made. The late Dr. Arthur H. Hawkins had just left Mt. Savage and persuaded Dr. Owens not to leave Cumberland. He said Dr. Owens had a continuous smile, a bedside manner second to none and moreover he was not afraid to work.

A few years later, he married Mrs. Betty C. Edwards, of Cumberland. They have no children of their own, but Dr. Owens gave much of his time to the Child Program in the Kiwanis Club.

Since retiring, he likes to talk about how few of his patients ever came to require a cesarean section; less than two per cent. For six years now, he reads and visits with his former patients, friends and physician friends. Not able to leave his room, his thoughts go back to yesteryears, but his plans go far into the future.

Live a simple and a temperate life, that you may give all your powers to your profession. Medicine is a jealous mistress; she will be satisfied with no less.

—Osler, Sir William

Dr. Charles Llewellyn Owens

CENTRE: DR. THOMAS F. LUSBY

DR. LUSBY OPENS OFFICE IN CUMBERLAND

Announcement was made by Dr. Thomas Frank Lusby, that he will locate in Cumberland, in the practice of surgery. For the past ten years, he has engaged in the general practice of medicine and surgery at Oakland, Maryland. He is a graduate of the University of Maryland, Class of 1941, and obtained his surgical training in Maryland General and Franklin Square Hospitals, Baltimore, Maryland.

The granting of privileges to undertake a simple procedure, while denying them for more difficult ones, indicates a disregard both of the problems in surgery and the safety and welfare of patients.

—Hawley, Paul R.,—The General Practice of Medicine, Bulletin A.C.S. Vol. 41, No. 5, P. 205, 1956.

PERSONALS

Dr. G. Overton Himmelwright, of Cumberland, recently completed a course in Management and Treatment of Diabetics, at the Ohio State University Hospital, Columbus, Ohio. Representatives of leading Diabetic Clinics throughout the country, including Dr. E. P. Joslin, Boston, Mass., participated. Dr. Himmelwright is a graduate of the University of Maryland, Class 1953 and is doing general practice in Cumberland.

Dr. Wylie M. Faw, Jr., Cumberland, was appointed surgical consultant to the New Romney, West Virginia, Memorial Hospital, at which Dr. Earl Paul will be resident surgeon.

Drs. Calvin Y. Hadidian and Earl R. Paul have opened offices in Cumberland, for the practice of chest surgery.

Dr. W. Royce Hodges addressed the Junior Chamber of Commerce Auxiliary of Cumberland, as well as other organizations, on the Blood Program of the American Red Cross and included a film showing, titled "Prescription for Life."

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

President Grant Ward called his last meeting of the Executive Board on Tuesday, 18 December 1956. Dr. C. Reid Edwards, President of the Medical and Chirurgical Faculty, but in this instance representing the Hospital Council, discussed the involved problem of the drunken driver in the magistrate's courts. For many years the onus of establishing whether a driver is drunk or not has been put on the patrolman making the arrest. The Police Department has been eager to have this function taken over by people more scientifically quali-

fied to pass judgment. Dr. Edwards and the Council felt that, since 32 states use some sort of test to determine alcohol levels, that Maryland should also legalize a test and put the carrying out of it in the purview of the Medical Examiner's office. He felt that hospital internes should not be involved in the problem. It was agreed to appoint a committee to work with Judge Scherr and Commissioner Hepbron on a solution to this perennially vexing problem.

Zoning continues to vex physicians and dentists even though the recently contested "St. Paul Street" eviction attempt has lapsed. Dentists and physicians attempting to establish themselves in nearby areas have been denied the privilege. Dr. Douglas Browning, President of the Baltimore City Dental Society, came to discuss this mutual problem. He urged doctors and dentists to work together to settle the zoning problem once and for all. We all recognize the value of nearby practitioners as an aid to public health, convenience to parents and patients, and in enhancing the value of property they occupy. He felt that to install carry-out grocery stores and dry-cleaning establishments in apartment houses, yet deny physicians and dentists office space in the same building as public nuisances, was definitely awry.

Dr. Classen, Secretary, stated that legal counsel, Mr. Anderson, had suggested that eventually the City Society would have to take steps to initiate legislation to overcome these problems once and for all. The President was directed to appoint a committee to work with the Dental Society and try to arrive at some solution.

Consideration was given to the proposed Amendment to the Constitution and By-Laws Regarding Nominations. The Board then went on record as opposing the measure for several reasons: 1) the present method has been in use less than 2 years, 2) a tendency to negate the value of continuity in office, 3) a failure to appreciate the tremendous amount of time that the Board members are called upon to give, and 4) a tendency to subordinate the scientific to the political aspects of the Society. Most of the members felt that any attempt to get new blood into the organizational structure was good, but did not believe this was the way to go about it. They view with horror the prospect of irresponsible individuals being elected to represent the organization as the possible result of political maneuvering. Public relations between organized medicine and other professional, as well as labor, groups have been fraught with heavy hazards through the last decade. It is to the great credit of our past presidents, secretaries, and treasurers that Baltimore City medicine has been practically unscathed.

Dr. Robert C. Kimberly, Treasurer, introduced a liability insurance plan, backed by Lloyd's of London, in answer to the many protests against the rising tide of costs of liability coverage. The four advantageous features of the plan are: 1, Rate based on experience within this Society alone. 2, Uncancellable within the three year term of the policy. 3, A three year rate guarantee for the contract. 4, No case could be settled without the consent of the insured. It was moved to present the plan to the Society.

The January meeting of the Baltimore City Medical Society was held on Friday, 4 January, in Osler Hall. Dr. Martin Gross, vice president of Carroll County Medical Society, was an invited guest and very ably represented his confreres of Carroll County in general and of Spring Grove State Hospital in particular. Also among us were Dr. Page C. Jett of Calvert County, and Dr. Hugh W. Ward of Calvert County, who has been voted Maryland's "General Practitioner of the Year." President G. Allen Moulton and Secretary-Treasurer Bill Cullwell, Mount Airy, could not be present.

President Frank Geraghty presided efficiently at this, his first meeting. The minutes were approved, and ten new members were elected. Dr. Amos Koontz presented a gavel to outgoing president Grant Ward in his most gracious style. The proposed amendment to the Constitution regarding the nominating committee was read to the meeting by Dr. Moses Paulson, Chairman of the Constitution Committee, as required by the Constitution. This was passed over without comment for final action at the February meeting.

The Scientific Session was then given over to Dr. Robert W. Buxton, Professor of Surgery at the University of Maryland Medical School, who spoke on "Treatment of the Postthrombotic Leg." His excel-

lent slides elaborated the history, incidence and periodicity of this condition, as well as the various types. He declared that the study of careful statistics of ligation at various levels found them to be "all unsatisfactory" in some measure. Ultimately the sufferers must find a "new way of life" and follow the well known "8 hygienic measures" that are most helpful.

The Woman's Auxiliary was on hand with delightful refreshments, dispensed by Mrs. Carl Ebeling and Mrs. William D. Lynn—to whom go many thanks.

The January meeting of the Executive Board of the City Medical Society considered the Phillips Amendment regarding the composition of the Nominating Committee and the election of officers. There seemed to be a general feeling that, while the intent of the change was worthy, the methodology proposed was dubious. Of particular hesitancy was the expected loss of the continuity-value inherent in the presently evolved method. Nomination of two individuals per office, as was proposed, would, it was felt, subordinate service to personality as the basis for a 'popularity contest.' The added disadvantage of secret ballots 'writ by hand' delaying fast moving meetings of today is exemplified by the fairly universal custom of not having them. The whole Baltimore community, furthermore, was felt to have a stake in its organized medicine. This stake would be jeopardized in the hands of officers without the background given to the present system by progressive service and training.

Dr. John M. Scott, our member-representative to the Division of Medical and Health Agencies of the Baltimore Council of Social Agencies, brought before the Board full details of the latest effort at streamlining the commitment problem in acute psychiatric emergencies. About 800 of these occur annually. In essence it envisages a reform of the present habit of remanding to the Baltimore City Jail by legalizing a five day 'confinement without commitment' in a hospital with psychiatric purview. It was pointed out that the police are careful to bring suitable cases to hospital accident rooms now, and that the death of about two such individuals in their cells per year compares favorably with the death rate of similar individuals not in jail. The report was routed to the Magistrate's Committee to work with the Legislative Committee with guidance from the Sections on Internal Medicine and Neuro-psychiatry.

At the regular meeting of the Society on Friday, 1 February, President Dr. Frank Geraghty introduced the guests of the evening, Dr. John H. Griffin, President, and Dr. J. Parran Jarboe, Secretary-Treasurer, from the Charles County Medical Society.

Reading of the minutes was dispensed with and the proposed amendment to the Constitution and By-Laws regarding the composition of the Nominating Committee and requiring dual candidates for each office was then presented by Dr. Moses Paulson, chairman of the Committee on Constitution and By-Laws. Several individuals spoke in opposition to the change as presented and one spoke in favor of the Amendment. A written ballot was called for and taken. The scientific session proceeded while the count was made. The final count showed 115 against and 81 for. The motion was lost. Although the ballot was written, it could not be called secret. In order to ascertain that only those entitled by full membership to vote did so, each ballot had to be signed. It was either do this, or exclude from the room all those ineligible to vote.

"The Management of Hypertension" was presented by Dr. George Perera, associate professor of Medicine, Columbia University College of Physicians and Surgeons. He capably presented the concepts underlying the modes of therapy prevailing today, with advantages and limitations of each. He discussed his own basic philosophy motivating his therapeutics and declared that sympathectomy was probably the most generally useful procedure. A lively discussion followed, topped off by delicious coffee, cocoa, and doughnuts and cakes served by the Woman's Auxiliary.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.
Journal Representative

The January meeting of the Baltimore County Medical Association was held on January 23rd,

after having been postponed a week, due to the heavy snows. The site of this meeting was the Stella Maris Hospice on the Dulaney Valley Road beyond Towson. This is a home for the aged run by the Catholic Church. Sister Mary Celeste welcomed the doctors and their wives, and a delightful fried chicken luncheon was served by her capable staff.

This was the first meeting at which our new slate of officers officiated. The officers are: Dr. William Pillsbury, of Timonium, President; Dr. Clarence McWilliams, of Owings Mills, Vice-President; and Dr. C. Lee Randol, of Pikesville, Secretary-Treasurer.

Dr. Charles O'Donnell discussed the Secondary School Nursing Program. It has been approved by the County Commissioners, the County Health Department, and the Parent-Teachers Association. It needed approval by the medical society, which it received. More details on this new program will be forthcoming.

Dr. Richard von Rigler brought up the problem of the Hungarian refugee doctors. What can we, as professional colleagues, do to help these unfortunates? It is a far-reaching problem that involves state laws, the State Board of Medical Examiners, and the high standards of our medical profession. A committee was appointed to investigate this matter.

It was recommended by Dr. Randol that an Addressograph machine be purchased by the association to facilitate mailing notices to members. This was approved unanimously.

Dr. Louis Dalmau discussed the polio vaccination program for adults. The vaccine is easily available now and should be used on a much wider scale. The National Foundation states that only one per cent of the population over ten years of age has been inoculated. This must be increased to 85 per cent by August. The ten to forty year age group is a highly susceptible group. The inoculation program will be more strenuously advertised to the public. In this regard, the medical society passed two resolutions to further the polio program.

The remainder of the afternoon was spent touring the Stella Maris Hospice.

CAROLINE COUNTY MEDICAL SOCIETY

ROBERT H. WRIGHT, M.D.

Journal Representative

The Caroline County Medical Society was host at the quarterly meeting of the Upper Eastern Shore Medical Society on January 17. Amid the snow and ice the attendance was good, to receive the speaker, Dr. Alexander Dowling, Jr., Medical Director, Chronic Disease Program, State Health Department. General discussion of the Chronic Disease Hospital program followed a film on "Care of the Hemiplegic."

Dr. Perry F. Prather further discussed the hospital program, criteria for admission, and financial limitation of patients.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The regular January meeting was held on the 15th at the Francis Scott Key Hotel. It was a charming tableau. The blazing logs on the hearth cast a flickering roseate glow on the festive board. The clink of ice in the glass could be heard above the soft murmur of voices. The soft fat snow flakes drifting against the panes made the atmosphere even more comfortable. But the guest speaker, Dr. Sam Bessman, who was to bring us up to date on the use of oral drugs to control hyperglycemia in chill bites, was deprived of all this. The complementary snow blocked him.

The hospital medical staff met on January 7th. After business was completed, Dr. Chase presented a case of pernicious anemia with atypical symptoms.

At the medical department meeting, presided over by the newly elected Chief of Medicine, Dr. Thomas Stone, a case of subdural hematoma diagnosed ante mortem as a C.V.A. was discussed.

The case of the January C.P.C. was one of paroxysmal ventricular tachycardia in a 73 year old male who died on the 3rd day. There followed a most instructive discussion of the physiology underlying this and other disturbances of cardiac rhythm and the use and effects of digitalis.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

JOHN W. PERKINS, M.D.

Journal Representative

Dr. Leslie French, cardiologist at Prince George's General Hospital, Cheverly, Maryland, has been invited to give a course in Practical Electro-cardiographic Analysis in Columbus, Ohio.

WASHINGTON COUNTY MEDICAL SOCIETY

HOWARD N. WEEKS, M.D.

Journal Representative

The Washington County Medical Society and the Washington County Dental Society, in cooperation with the Board of Trustees of the Washington County Hospital, held a dinner meeting at the Fountain Head Country Club, Thursday evening, January 31, 1957.

A cocktail hour preceded the delicious dinner served to some one hundred doctors, dentists, nurses and members of the Board of Trustees.

The speaker for the evening was Dr. George J. Thomas, Chairman of the Section on Anesthesiology at the University of Pittsburgh, School of Medicine and Director of the Department of Anesthesiology at the St. Francis General and Medical Hospital, Pittsburgh, Pa.

His talk opened with a bang—literally. Dr. Thomas had brought a miniature surgical apparatus, including cylinders of ether and cyclopropane. To begin his talk he suddenly loosed an explosion that sounded like a large-size firecracker. "Explosions come at the most unexpected times," he said. He was, of course, referring to operating room explosions and their accompanying hazards. Emphasis was put on the position of static electricity being generated and he demonstrated this point by making explosions that were the direct result of static electricity combining with ether, oxygen or ordinary air.

An interesting note was inserted, namely: that our own hospital holds such risks to a minimum. Dr. Ernest F. Poole, Chief of the Anesthesiology Department, stated: "In our new hospital, code 56, has been followed in the construction and maintenance of our operating rooms. We feel that we are well abreast with all modern safety precautions."

Dr. Thomas also elaborated on this code. He further stated that conductive materials must be used in operating rooms at all times to ground the equipment and prevent a build-up of static. Such devices as conductive flooring, conductive casters on operating room tables, attaching of chains and straps from equipment and persons to the floor, use of conductive rubber for breathing tubes and bags, and the use of cotton clothing and shoes; all are parts of safety measures. Following his most enlightening demonstrations, a question and answer period brought out other points which were of much interest.

The Annual Meeting of the Washington County Medical Society met in Dorsey Hall on January 24, 1957, for the election of officers for the coming year:

Dr. W. H. Shealy—President
Dr. J. W. Layman—Vice President
Dr. E. F. Poole—Secretary-Treasurer

Delegates—Dr. W. T. Layman, Dr. G. W. LeVan
Alternates—Dr. John James Dobbie, Dr. John A. Moran

There is no further news concerning the Washington County Medical Society other than the death of our beloved colleague, Dr. Peregrine Wroth. His career was a memorable one. I feel certain that his accomplishments and a resume of his medical career have already been made mention of in another section of the publication.

Necrology*

Peregrine Wroth, M.D.†
1882–1956

Dr. Peregrine Wroth, distinguished surgeon and long-time dean of the medical profession of Hagerstown, died December 25, 1956.

He was born in Baltimore on February 17, 1882, the son of the Rev. Peregrine Wroth, one of Baltimore's best known Episcopal rectors, having served at the Church of the Messiah for over half a century. The Wroth family came from the Eastern Shore of Maryland, and is one of Maryland's oldest, tracing its beginnings in Kent County back to 1650. His paternal grandfather was a popular and well known family physician in that county, accounting in part for Dr. Wroth's early decision to enter the same field.

Educated in the public schools of Baltimore, Dr. Wroth was graduated from Johns Hopkins University and from Johns Hopkins Medical School. After his internship and surgical residency at the Union Protestant Infirmary, he went to Hagerstown in 1908 and first practiced in the old hospital at the corner of Potomac and Fairground Avenues, recently razed. There he helped formulate the first rules of asepsis for the operating room. Soon after his arrival he began to utilize his skill and training by organizing and directing the King's Daughters Clinic, which was to evolve into the Washington County Health Association. He was a charter member of the staff of the Washington County Hospital, later serving as its president, and had held the post of chairman of the surgical committee of the hospital since its organization in 1956.

Dr. Wroth took great pride in his service on the building committee of the Bloom Memorial Wing and later on the huge expansion of the hospital completed only a few years ago. Despite the increasing demands on his time with the passage of the years, he also continued to serve as chief surgeon for the local Potomac Edison Company and for the Western Maryland Railway, although since the heart attack suffered seven years ago he had greatly curtailed his surgical activities. Residents of nearby Pennsylvania communities will remember particularly his role as consulting surgeon at both the Waynesboro and Chambersburg Hospitals, the same capacity which he filled for the Maryland Tuberculosis Sanitarium.

DR. PEREGRINE WROTH

He served as a captain in the Medical Corps during World War I, at which time he was sent to France, where he served with the Johns Hopkins Unit at Base Hospital 18. During World War II, Dr. Wroth shared the increased burden of surgical practice occasioned by the call of younger members of the profession into the Armed Forces.

During his very active career he was a fellow of the American College of Surgeons, the American Medical Association and the Southern Medical Association. He was also a member of the Founders Group of the American Board of Surgery and was elected a diplomate of the Academy-International of Medicine.

Indicative of his service here in Maryland was Dr. Wroth's record as a member of the Medical and Chirurgical Faculty of Maryland, having served as

* Memoir Committee: A. S. Chalfant, M.D., *Chairman*, John F. Hogan, M.D. and Robert H. Riley, M.D.

† Excerpts from the *Bulletin of the Medical Staff*, Washington County Hospital.

president of the group in 1928, and as a member of the Advisory Council on Hospital Construction in the state, and also having served with distinction on the Medical Care Committee of the Maryland State Planning Commission.

Dr. Wroth's social affiliations reflected his own interests, beginning with his membership in the Hopkins Club in Baltimore and his long membership in the Maryland Historical Society. Keenly interested in history, particularly that of his home state, Dr. Wroth was recognized as an authority on Antietam and other Civil War battlefields. He was also an ardent student of medical history, especially that of early medicines and practices in this country and his state.

His principal hobby was photography. He was a former vestryman of St. John's Episcopal Church, a trustee of St. James School, and a charter member of the Hagerstown Rotary Club.

Dr. Peregrine Wroth had the boundless energy, interest, and enthusiasm which distinguishes the leader from the plodder. These gifts he devoted to the service of his patients in Hagerstown, the Washington County Hospital and indeed to the State of Maryland in so effective a way that the Medical and Chirurgical Faculty is proud to remember him as our past president, eminent counsellor and ideal surgeon, worthy of the honored affection with which his name will always be remembered.

Vincent Gould, M.D.
1900–1956

Dr. Vincent Gould was born in London, Ontario, January 15, 1900. During World War I, he left college to enter the Royal Canadian Air Force, where he distinguished himself as one of the youngest of their gallant pilots. After the war he finished at McGill University and at Columbia, adding M.S. to his B.A. and going on to take his M.D. at George Washington University Medical School, where he graduated first in his class in 1929.

Dr. Gould did a great deal of major surgery until he developed cataracts. It was indicative of his character that this merely stimulated his interest in the subject and led to special study on the biochemical aspects of cataract, which he reported in the journals. When eye operations necessitated stopping surgery, his idea of retirement was to enter an active country practice in Mayo, Anne Arundel County, where he continued work from 1946 until his death on November 7, 1956. Much more might be said of his work, but he was not a man to talk much about himself and perhaps that is a good way to remember him.

Dr. Gould was a member of the George Washington Medical Society, the American Medical Association and the Medical and Chirurgical Faculty of Maryland.

He is survived by Mrs. Gould and two sons.

A.S.C.

Henry Lee Smith, M.D.
1869–1957

Dr. Henry Lee Smith died on January 9, 1957, at the age of eighty-eight. He had fallen in his home the day after Christmas and fractured his hip.

Dr. Smith was born in Ashland, Virginia, the son of Major John Thomas Smith and Margaret Lewis Marshall, granddaughter of Chief Justice John Marshall. He graduated from the Episcopal High School of Virginia, before going on to the University of Maryland, where he won the Medical Medal in 1894. Following the custom of the more fortunate graduates of that period, he then spent several years abroad, in the Universities of Marburg, Gratz and Berlin, and did original work in bacteriology.

After his return to Baltimore he was on the faculty of the Women's Medical College, but also spent part of his time in the Medical Dispensary of the Johns Hopkins Hospital, where he taught medical student groups physical diagnosis, until he resigned as Associate in Medicine in 1935. He was a captain in the Army during the Mexican border campaign and a major in World War I. He was connected with the Veterans Bureau in the early 1920's.

Dr. Smith was a well-educated man and though all his publications were in the earlier years of his career, he will be remembered by the scores of students whom he instructed for his great interest in literature and for the originality of some of his methods of instruction. After his retirement from practice in 1948, he wrote poetry for his own interest and in 1951 privately published a book of poems, entitled "Shells."

He is survived by his wife, Eloise G. Henry Smith, two sons, Robert Lee Smith and Henry Lee Smith, Jr., and several grandchildren.

Dwight Harold Mohr, M.D.
1886–1956

Dwight Harold Mohr, Major General, Maryland National Guard, retired, a former commander of the 104th Medical Regiment and surgeon, 29th Infantry Division, died in Bon Secours Hospital, Baltimore, Maryland, on November 6, 1956, following a cerebral vascular accident.

General Mohr was born on December 3, 1886, at New Haven, Connecticut. His father, the Rev. Ursinus O. Mohr, a former chaplain with Theodore Roosevelt's "Rough Riders" in Cuba during the Spanish-American war, and his mother, Mary Shirk Mohr, were of German stock and natives of Connecticut.

General Mohr was graduated from the Maryland Medical College in 1909. His pre-medical education was obtained at Trinity College, New York, from which he was graduated in 1905. In college he distinguished himself in athletics, having served as captain of the football team, pitcher on the baseball team, and won an intercollegiate championship in boxing.

Following his graduation in medicine, he served an internship at Flower and Bellevue Hospitals in New York. Returning to Baltimore, he was associated for a time with Prof. Pearce Kintzing, one of the leading internists of his day. He eventually located in the Patterson Park district of Baltimore, where he engaged in general practice, soon became well and favorably known, and was beloved by a large following both as physician and friend.

In 1915 he was commissioned a first lieutenant in the Medical Corps of the Maryland National Guard, an association which was to launch him upon a distinguished medico-military career. He saw service on the Mexican border during the Villa incident, when U.S. troops were dispatched to that area, and also served with distinction in the 104th Sanitary Train, 29th Division, through World War I. He was mustered out of service with the rank of captain when the division was disbanded in 1919.

However, he was not to be divorced from the military for long. In November 1920 steps were taken to organize the 104th Medical Regiment and he accepted a commission as Major and with energy and enthusiasm contributed much to the organization and training of that unit. When the Guard was activated in February 1941 he was its commander with the rank of Colonel but having developed some disqualifying physical defects was not permitted to lead it in its brilliant record established in World War II.

With the departure of all National Guard troops the security of the State was jeopardized. At the direction of Governor Herbert R. O'Conor, Colonel Mohr was given the rank of brigadier general and organized the State Guard to take the place of the militiamen who had gone into Federal service.

That he did his job well can best be judged by the fact the War Department gave the Guard a top rating in comparison with similar organizations of the other States. In May 1943, as a result of this top rating an invitation was extended through the British Embassy in Washington to General Mohr and two aides to visit England, inspect its Home Guard, and exchange views and military information. On his return from this important mission Governor O'Conor promoted him to the rank of major general. During the meeting of the 1945 State Legislature a resolution commending General Mohr for his "unselfish and untiring efforts in the organization and training of the Guard" was offered by the House Military Committee.

On July 1, 1920, Dwight H. Mohr, M.D., was appointed Chief Physician and Medical Director for the Baltimore City Police Department, a position he was to fill with distinction until his death. So it was that for more than 36 years, working with and under the supervision of six different Police Commissioners and five Chief Inspectors, he directed a group of staff physicians in a manner that brought forth a service which ever reflected credit upon the department.

General Mohr was a member of the Medical and Chirurgical Faculty of Maryland, the Southern Medical Association and the Association of Military Surgeons of the United States. He served on the Executive Council of the latter organization for many years. His devotion to the military, the police department, and the private practice of medicine did not detract from his interest in some of the less exacting and more frivolous pursuits of life. He was an ardent hunter of small game, an accomplished yachtsman, and greatly enjoyed flying an aeroplane and was known to "buzz" the housetops of close friends on occasion just for a lark.

He was courtly in bearing, cultured, and with

many interests. He had a host of friends and ever displayed a loyalty which placed friendship above and beyond the ordinary. Those who knew him best loved him most. With respect to his many qualities one could say he was abounding in vitality, mental and physical, quick and accurate in decision, and prompt in action. He understood men and knew how to work with them for the common good. He was far-sighted in planning and unusually able in administration. He was loyal always, but courageous in promoting sound views and steering away from error.

General Mohr was married to Margaret Lens of Baltimore, Maryland, who survives him. Funeral services were held at a private chapel in Baltimore on November 9, 1956, burial was with military honors and Masonic participation in Arlington National Cemetery.

WILLIAM H. TRIPLETT, Col., M.C., U.S.A.

Henry Benedict Athey, M.D.
1878–1956

Dr. Henry Benedict Athey, a prominent practitioner of the City of Baltimore, died at his home, 2504 St. Paul Street, on December 8, 1956.

Dr. Athey was born in Leesburg, Virginia, in June 1878, the son of Captain William W. Athey, who fought with General Robert E. Lee, and Isabella Rinker Athey of Leesburg, Virginia. After working for a while for the Baltimore and Ohio Railroad in Baltimore, he decided to give up his position and study medicine, enrolling in the University of Maryland School of Medicine.

Following graduation from the University of Maryland in 1911, he interned for a year in a hospital in Newark, New Jersey. From 1912 until his death he practiced medicine in the City of Baltimore, where he was deemed invaluable by his many patients over this long period of years.

J. F. H.

W. J. Coleman, M.D.
1881–1956

Dr. William J. Coleman was born in London, England, on February 21, 1881, the son of Joseph S. and Hannah Coleman.

His family moved to New Haven, Connecticut, when he was nine years old. He received his early education in London and New Haven and graduated from the University of Maryland School of Medicine in 1908.

Dr. Coleman was a member of the surgical house staff of the University Hospital from 1908 until 1911 and was Medical Superintendent from 1911 until 1917.

He served with the Maryland National Guard on the Mexican border as a captain in the Medical Corps. He was later promoted to major in the Medical Corps of the United States Army and went to France with the 29th Division. He was later assigned to Evacuation Hospital No. 8, where he was chief of an operating team. After the Armistice, he went into Germany with the Army of Occupation and was promoted to Lieutenant Colonel and assigned to Evacuation Hospital No. 27. Subsequently he was made Chief of the Surgical Service of the Evacuation Hospital No. 26. He returned to the United States and was discharged from the Army in 1920.

He was Superintendent of the Maryland General Hospital from July 1921 until 1924. He then practiced surgery until 1956.

Dr. Coleman was married to Miss Laura Schley Chapline in 1917. He is survived by his son, William J. Coleman, Jr., D.D.S., and his daughter, Laura Chapline Loughrie.

Dr. Coleman died at the Maryland General Hospital on November 25, 1956, following a long illness.

C. A. REIFSCHNEIDER, M.D.

William Shepherd Hall, M.D.
1876–1956

Dr. William Shepherd Hall, a prominent practitioner of the City of Baltimore, died at the Union Memorial Hospital on November 25, 1956. He was born in Bel Air, Maryland, on May 15, 1876, the son of Edward H. and Lydia Haynes Hall.

The Doctor's grandparents were Thomas White Hall and Caroline Howard Hall. Thomas White Hall, the grandfather, was the owner of Constant Friendship (named after a ship in slave trade by its Captain—Captain Dyans—and sold by him to Mr. Hall).

Dr. Hall's mother, Lydia Haynes, was born in Norfolk, Virginia, but moved to Bel Air as a child.

His father, Edward H. Hall, went to school in Virginia and served during the Civil War with the Confederate Army. It was after the war that he married Mrs. Haynes.

Dr. Hall was graduated from the University of Maryland Medical School in 1899. Following graduation, he interned at Saint Joseph's Hospital in Baltimore. During his medical career he served on the staffs of St. Joseph's, University, Johns Hopkins Hospitals and the Union Protestant Infirmary. For many years Dr. Hall was on the Board of Police Physicians. He was a member emeritus of the Medical and Chirurgical Faculty, a member of the Maryland Historical Society and in his younger days belonged to the Maryland Whist Club and the Baltimore Athletic Club.

Dr. Hall was owner of part of Constant Friendship and of Glebeland, the latter being the site of old St. John's Parish (Episcopal).

He was five times descended from the Hon. John Hall (1660–1737) who was a member of Lord Baltimore's Council. The Doctor was also descended from Robert Morris, a signer of the Declaration of Independence.

The Doctor's opinion on his medical experience was that "horse sense" was the best part of a good physician. His friends termed him a good friend, an excellent citizen and an understanding physician.

J. F. H.

Oliver S. Lloyd, M.D.

1884–1956

Dr. Lloyd was born in Western Run, Baltimore County, Maryland, on July 9th, 1884. He received his medical degree from the College of Physicians and Surgeons, now combined with the University of Maryland, in 1909.

He served his internship at the Mercy Hospital where he became Resident in Surgery. He practiced his chosen profession, Surgery, ethically and honestly and soon gained recognition for his sympathetic understanding of the needs of his patients. His untiring efforts and excellent surgical judgment soon earned him many places of importance.

He became Chief Surgeon to the Baltimore City Fire Department in 1928, where he continued to serve with distinction until the time of his death. He was a member of the staffs of Mercy Hospital, Lutheran Hospital and the South Baltimore General Hospital. He was an organizational member of the South Baltimore General Hospital and served as Chief Surgeon of the institution from 1945 to 1952, when he resigned. He was a member of the American College of Surgeons, International Surgical Congress, Southern Surgical Congress, Southern Medical Association, American Medical Association and the Baltimore City Medical Society.

He was also a member of the Baltimore Country Club, Skytop Club and was closely associated with the Young Men's Christian Association for over 45 years.

He was intensively interested in outdoor sports and was an authority on game hunting. He excelled in rifle markmanship, golf and wrestling.

He received high commendation from the Board of Commissioners of the Baltimore City Fire Department for his moral and physical courage while on duty at many serious fires. His kindness and sincerity earned him the respect and admiration of the entire department. This tribute and appreciation of his services was quite evident by the Fire Department who formed the court of honor at his funeral.

Dr. Lloyd was also endowed with the art and ability to create many skillful and practical scientific gadgets; the most ingenious one being the development of a hip screw in the treatment of fractured hips, which pin bears his name, the Lloyd Hip Screw. In the development of this screw, he conducted considerable research studies with many different metals and techniques before finding the best metal suited for this operation.

Dr. Lloyd died on October 27th, 1956. He is survived by his wife, the former Miss Jane Scott, a son, Galvin Lloyd of Winchester, Va., and a daughter, Mrs. Frederick Stuart, Jr., of Baltimore, a sister, Mrs. Ethel Lloyd Morse of Baltimore and a brother, Lowndes Lloyd of Syracuse, New York.

GEORGE MCLEAN, M.D.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

LIBRARY CHATTER

LOUISE D. C. KING

Librarian

In order that one may evaluate certain therapies and phases of medicine or related fields, it is necessary to inform oneself, either discarding them as not sufficiently proven, as empirical, or perhaps deciding that they are worth a trial.

Hardly a month goes by without something being brought forth, and with our present objective of educating the public, and the press only too eager to assist us, the patient hears about much that is still in the experimental stage and naturally wishes the doctor to be informed as to the efficacy and suitability to his or her case. The Library receives many calls as to whether certain treatments are approved or not, and the answer is always to advise consultation with their doctor. You can help them if you have read up on the subject.

The two brief bibliographies below are subjects on which your patients may desire information. It is not enough to raise the eyebrow; your patients will wish a satisfactory answer.

The references below are all in English and are in journals which may be borrowed from your own library. Two journals subscribed to but not analyzed: ANNALS OF THE RHEUMATIC DISEASES and BULLETIN ON RHEUMATIC DISEASES.

RHEUMATISM

1954

Bornstein, J. & others. Intra-articular hydrocortisone ascetate . . . GERIATRICS 9: 205–210 My. 1954

Bunim, J. J. Research activities in rheumatic diseases. PUB. HEALTH REP. 69: 437–440 My. 1954

Cone, R. B. & others. Erythema multiforme bullosum following phenylbutazone treatment for arthritis. ARCH. DERM. SYPH. 69: 674–677 Je. 1954

Drew, J. F. Some aspects of pain in chronic rheumatic disease. MED. J. AUSTRALIA 41 v. 2: 701–704 30th O. 1954

Hartfall, S. J. Stress and rheumatic disorders. PRACTITIONER 172: 29–36 Ja. 1954

Hollander, J. L., ed. Symposium on efficacy of new drugs. MED. CLIN. N. AMERICA, NATIONWIDE No. Mr. 1954

Kelly, M. Phenylbutazone (butazolidin) good or evil? Anti-rheumatic or analgesic? MED. J. AUSTRALIA 41 v. 2: 504–507 25th Se. 1954

Klein, R. Rheumatic diseases, rehabilitation and the general practitioner. GP 10: 49–55 Ag. 1954

Mintz, B. & Goldwater, L. J. Occupational aspects of rheumatic diseases; a review. INDUST. M. & S. 23: 335–342 Ag. 1954

Waine, H. Review of rheumatic diseases. ARCH. INT. MED. 93: 121–161 Ja. 1954

1955

Bartfeld, H. Use of reserpine in psychogenic rheumatism . . . a preliminary report. J. AM. M. ASS. 159: 1510–1513 17th D. 1955

Bastow, J. The surgery of rheumatic disease. POSTGRAD. M. J. 31: 635–640 D. 1955

Batterman, R. C. & Grossman, A. J. Effectiveness of salicylamide as an analgesic and anti-rheumatic agent. . J. AM. M. ASS. 159: 1619–1622 24th D. 1955

Begnall, A. W. A new technique for the local use of hydrocortisone in rheumatic disease. CANAD. M. ASS. J. 73: 972–973 15th D. 1955

Done, A. K. & others. Studies of 17-hydroxycorticosteroids xiii Effects of salicylate intoxication in rheumatic and non-rheumatic subjects. J. PEDIAT. 47: 727–732 D. 1955

Freyberg, R. H. The use of hormones in rheumatic diseases. J. CHRONIC DIS. 2: 559–582 N. 1955

Howard, L. D. Jr. Surgical treatment of rheumatic tenosynovitis. AM. J. SURG. 89: 1163–1168 Je. 1955

Kuhns, W. J. & Crittenden, J. Zone electrophoresis in studies of serum proteins, protein-bound polysaccharides and serum lipids in rheumatoid diseases. J. LABORAT. CLIN. M. 46: 398–408 Se. 1955

Lawrence, J. S. Rheumatism in coal miners. iii Occupational factors. BRIT. J. INDUST. M. 12: 249–261 Jl. 1955

Losner, S. & Volk, B. W. The fibrinogen polymerization test in active rheumatic disease. AM. J. M. SC. 229: 371–378 Ap. 1955

Lowman, E. W. Psychogenic rheumatism. ARCH. PHYS. M. 36: 222–226 Ap. 1955

McCulloch, H. A sanitarium for the treatment and study of rheumatic diseases. PEDIATRICS 15: 603–604 My. 1955

McEwen, C. & Ziff, M. Basic sciences in relation to

rheumatic diseases. MED. CLIN. N. AMERICA, N.Y. No. My. 1955 p. 765–782

May, F. A study in focal infection and its relation to rheumatic disease. ARCH. PHYS. M. 36: 751–758 D. 1955

Perlstein, I. B. Histamine as a stress combatting agent in the treatment of rheumatic disease. J. AM. GERIAT. SOC. 3: 997–1004 D. 1955

Sperling, I. L. Rheumatic diseases: the systemic and intra-synovial use of hydro-cortisone. MED. TIMES 83: 1010–1025 O. 1955

Tegner, W. Physical methods in the treatment of rheumatic disorders. POSTGRAD. M. J. 31: 632–634 D., 1955

Weiss, E. Psychogenic rheumatism. MED. CLIN. N. AMERICA PHIL. No. Mr. 1955 p. 601–612

Wirtschafter, Z. T. & others. Palindromic rheumatism . . . ACTA MED. SCAND. 153: 119–126 D., 1955

1956

Bonomo, E. & others. Comparative studies in serum polysaccharides in rheumatic diseases. ACTA MED. SCAND. v. 154, suppl. 312, 1956 p. 361–365

Cobb, S. & others. On the measurement of prevalence of arthritis and rheumatism from interview data. J. CHRONIC DIS. 3: 134–139 F., 1956

Heaton, T. G. Rheumatic or collagen pneumonia. CANAD. M. ASS. J. 75: 46–47 Jl. 1956

Mundy, V. G. von. Arthritis and pregnancy. ACTA MED. SCAND. v. 154 suppl. 312, 1956 p. 391–393

Najib-Farah. Fresh ox-bile percutaneously administered as . . . therapeutic agent in rheumatic and other affections. ACTA MED. SCAND. v. 154 suppl. 312, 1956 p. 596–608

Panel discussion on rheumatic diseases. J. AM. GERIAT. SOC. 4: 572–587 Je. 1956

Smith, R. T. & others. Zoxazolamine (flexin) in rheumatic diseases; preliminary report. J. AM. M. ASS. 160: 745–748 3d Mr. 1956

Ziff, M. & others. Excretion of hydroxyproline in patients with rheumatic and non-rheumatic diseases. J. CLIN. INVEST. 35: 579–587 Je. 1956

HYPNOSIS

1954

Cedercreutz, C. Hypnotic treatment of phantom sensations in 100 amputees. ACTA CHIR. SCAND. 107: 158–162 My. 1954

Jacobson, E. Relaxation methods in labor; a critique of current techniques in natural childbirth. AM. J. OBST. 67: 1035–1048 My. 1954

Raginsky, B. B. Preanesthetic management of the dental patient. J. AM. DENT. ASS. 49: 672–683 D. 1954

Rubenstein, R. & Newman, R. The living out of "future" experiences under hypnosis. SCIENCE 119: 472–473 9th Ap. 1954

Schneck, J. M. Countertransference in Freud's rejection of hypnosis. AM. J. PSYCHIAT. 110: 928–931 Je. 1954

Schneck, J. M. Ichthyosis treated with hypnosis. DIS. NERV. SYST. 15: 211–214 Jl. 1954

Shires, E. B. & others. Hypnosis in neuromuscular re-education. U. S. ARMED FORCES M. J. 5: 1519–1523 O. 1954

1955

Abramson, H. A. Reassociation of dreams. AM. J. PSYCHIAT. 112: 300–301 O. 1955

Busse, E. W. Application of hypnosis in medicine. SOUTH. M. J. 48: 310–314 Mr. 1955

Crasilneck, H. B. & others. The use of hypnosis in the management of patients with burns. J. AM. M. ASS. 158: 103–106 14th My. 1955

DeLee, S. T. Hypnotism in pregnancy and labor. J. AM. M. ASS. 159: 750–754 22d O. 1955

Eichhorn, R. & Tracktir, J. The effect of hypnosis upon gastric secretion. GASTROENTEROLOGY 29: 417–438 Se. 1955

Gwartney, R. H. Hypnosis in suppression of cough reflex. NEW ENGLAND J. M. 253: 561–562 29th Se. 1955

Heron, W. T. Principles of hypnosis. SOUTH. M. J. 48: 307–310 Mr. 1955

Mason, A. A. Surgery under hypnosis. ANAESTHESIA 10: 295–299 Jl. 1955

Meares, A. Anxiety reactions in hypnosis. BRIT. M. J. 1: 1454–1455 18th Je. 1955

Meares, A. A dynamic technique for the induction of hypnosis. MED. J. AUSTRALIA 42 1: 644–646 30 Ap. 1955

Meerloo, J. A. Medication into submission; the danger of therapeutic coercion. J. NERV. MENT. DIS. 122: 353–360 O. 1955

Nardini, J. E. & Jones, W. L. The challenging art of psychotherapy: materials and methods and uses of hypnosis. U. S. ARMED FORCES M. J. 6: 823–833 Je. 1955

Owen-Flood, A. Hypnotism and the anaesthetist. BRIT. J. ANAESTHESIA 27: 398–404 Ag. 1955

Rothman, I. Psychiatry and anaesthesiology (including hypnotism in anaesthesiology) INTERNAT. J. ANESTHES. 2: 186–190 Mr. 1955

Sackett, W. W. Jr. History of medical hypnosis. SOUTH. M. J. 48: 306 Mr. 1955

Schneck, J. M. Hypnoanalytic elucidation of motivation and goal in relation to psychotherapy. DIS. NERV. SYST. 16: 173–178 Je. 1955

Schwarz, B. E. & others. Hypnotic phenomena including

hypnotically activated seizures, studied with the electroencephalogram. J. NERV. MENT. DIS. 122: 564–574 D. 1955

Shane, S. M. Anesthesia for Frankie: A story for children. INTERNAT. J. ANESTH. 2: 172–184 Mr. 1955 (also in book form)

Singer, W. B. The use of hypnosis to overcome inability to tolerate retention of the Levin tube. GASTROENTEROLOGY 28: 669–671 Ap. 1955

Solovey de Milechnin, G. Conduct problems in children and hypnosis. DIS. NERV. SYST. 16: 249–253 Ag. 1955

1956

Asher, R. Respectable hypnosis. BRIT. M. J. 1: 309–313 11th F. 1956

Bryant, M. E. Hypnosis: its use in control of pain. NORTHWEST MEDICINE 55: 534 My. 1956

Mason, A. A. Hypnosis for the relief of pain. PROC. ROYAL SOC. OF MEDICINE 49: 481–486 Jl. 1956

Meares, A. The hysteroid aspects of hypnosis. AM. J. PSYCHIAT. 112: 916–918 My. 1956

Meares, A. Recent work in hypnosis and its relation to general psychiatry. MED. J. AUSTRALIA 43 v. 1: 1–5, 37–40 7th & 14 Ja. 1956

Norris, A. & Huston, P. Raynaud's disease studied by hypnosis. DIS. NERV. SYST. 17: 163–165 My. 1956

Schneck, J. M. Concept of assurance of illness reversability. DIS. NERV. SYST. 17: 191–193 Je. 1956

Schneck, J. M. Dynamic hypnotic age regression. AM. J. PSYCHIAT. 113: 176 Ag. 1956

Textbooks, chapters in systems of medicine, articles in state journals, etc. omitted because of lack of space.

FREE PARKING

There is a parking lot for the convenience of members maintained by the Medical and Chirurgical Faculty at the back of the building. Entrance is through the Maryland Avenue gate, between Preston and Biddle Streets, Baltimore.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Polio Vaccine—Now

The Baltimore City Health Department is convinced that the poliomyelitis vaccine now available is safe and effective. It strongly urges the widespread use of this vaccine in the city. Therefore, with the assistance of the medical profession, the Department has announced a program to protect the children of the city from this crippling disease, designed to bring such protection to those in need of it before the start of the poliomyelitis season next July.

Any child not so inoculated is in the opinion of the Commissioner of Health a neglected child.

The program is based upon surveys which the Department recently completed, which show the proportion of children vaccinated in each age group and in each area of the city. These studies indicated that with few exceptions:

I. Each age group in the Negro child population is far below the desirable protective level of 85 per cent vaccination. This is believed to have resulted in the relatively high attack rate experienced in this group in 1956.

II. Children living in the lower two socioeconomic fifths of the city have been found to be well below the desired level of protection.

III. Surveys of pupils in the secondary schools indicate that less than half of these students have had at least one inoculation.

Careful consideration of the problem of poliomyelitis in adults twenty years of age and over indicates that the risk is not great, for in recent years less than 18 per cent of the total paralytic cases among Baltimore residents occurred in persons more than 20 years old. The risk of attack in this adult group, with the possible exception of pregnant women, is not considered an imperative public health problem. Furthermore, it has been found that a significant factor in adult poliomyelitis is exposure of parents to infection by children.

In the light of these findings the Baltimore City Health Department has established the following policies in connection with poliomyelitis vaccination and the prevention of paralytic poliomyelitis.

1. A major responsibility for the protection of the community at all age levels rests with the private physicians. All parents who have a family physician are urged to have him inoculate their children if they have not yet had the full course of three shots, the first two doses a month apart, and the third dose six months after the second. It is hoped all adults 20 to 40 years of age will seek inoculation from their personal physicians.
2. For any family that is unable to make arrangements to have its children inoculated by a private physician, the City Health Department will provide a variety of facilities which are designed to reach, in a rapid way, the groups which were found to be least protected. These facilities include:
   A. Special school inoculation clinics in those areas with low protective levels. The clinics will be in selected elementary schools. Parental request cards have been sent to parents of the children in these schools. A similar program has been planned by the City Department of Education for the secondary schools.
   B. Neighborhood inoculation clinics for the preschool children in those schools which are not covered by the school inoculation clinics and for other persons under twenty years of age. These clinics are being held at the places and hours listed as follows:
      1. *Eastern Health District Building, 620 N. Caroline Street—Tuesdays at 12:30 P.M., and Fridays at 8:30 A.M.*
      2. *Old University Hospital Building, 601 W. Lombard Street—(Greene St. Entrance) Wednesdays at 12:30 P.M.*
      3. *Druid Health District Building, 1313 Druid Hill Avenue—Tuesdays at 12:30 P.M.*
      4. *Southern Health District Building, 1211 Wall Street—Friaays at 12:00 Noon.*
      5. *Southeastern Health District Building, 3411 Bank Street—Thursdays at 12:30 P.M.*

6. *914 West 36th Street—Wednesdays at 9:00 A.M.*
7. *2817 Oakley Avenue—Fridays at 8:30 A.M.*

C. Registrants of City Health Department well baby clinics and prenatal clinics will continue to receive the necessary inoculations to protect them against paralytic poliomyelitis, through these clinics.

D. The Health Department has no facilitiers fo the inoculation of people over 20 years of age, excepting for pregnant women.

Huntington Williams, M.D.

Commissioner of Health

STATE DEPARTMENT OF HEALTH

A Review of the Maryland Epilepsy Program

Dr. Jean Stifler, Chief, Division for Crippled Children and Heart Disease Control presented a paper on Maryland's Epilepsy Program at the last meeting of the American Public Health Association. The following data taken from this paper will be of interest to all physicians in Maryland.

Six years ago, in July 1950, with the help of the United States Children's Bureau, the Maryland Epilepsy Program was inaugurated to meet a need and to attempt to extend the benefits of modern therapy to patients living in rural areas. The program was designed and continues to be directed towards those children with convulsive seizures who are amenable to treatment but who do not require institutional care. The plan provides for case-finding, complete diagnostic work-up and arrangements for follow-up care.

Seizure clinics, staffed by visiting specialists from the teaching hospitals, were established in several county health departments. Children with epilepsy or suspected epilepsy are referred to these clinics by private physicians, schools, the County Health Department, or other agencies. Following initial screening in the county clinic, the children are sent either to the Johns Hopkins or University Hospitals for diagnostic work-up including history, physical examination and any necessary diagnostic procedures such as x-ray of the skull, blood chemistry or electroencephalograms. Thus, the already established centrally located hospital facilities are integrated into the program. A report of the hospital findings on each patient is sent to the family physician, to the county health department, and to the Division for Crippled Children of the State Health Department. After the hospital evaluation, the patient returns to the county clinic where medication is regulated and arrangements are made for follow-up care. The family physician is encouraged to provide day to day supervision with the county clinic offering consultation service when needed; the clinic follows those children who have no family physician.

This clinic service is available locally in 12 of the 23 counties of the State of Maryland. For the 11 remaining counties, no local clinic services have as yet been established but some clinics in adjacent counties serve several of these counties and the two hospital clinics in Baltimore City care for patients from nearby areas. During the year 1954, 665 patients received services under the Epilepsy Program. These patients made 1,297 visits to the county clinics and 548 visits to the hospital clinics. Five children were hospitalized.

During the 3½ years, from July 1950 to January 1, 1954, a total of 871 patients under the age of 21 were registered in the epilepsy clinics. To analyze the operation and effectiveness of the program and to facilitate future planning, a study was made of this patient load.

A total of 103, or 12 per cent, of these children were found to have no epilepsy and 79, or 9 per cent, did not return for complete studies and therefore had no final diagnosis. 689, or 79 per cent, were given a definite diagnosis of epilepsy.

It is significant that 12 per cent of the total number of children registered at the clinics were found to have "no epilepsy." This group included children with simple fainting spells, breath holding spells, behavior disorders and hysteria. The removal of the suspicion of epilepsy in any child is an important function of the program. These children, in whom no evidence of epilepsy was found, were directed to the proper treatment facility, such as their own family physician or a mental health clinic where appropriate treatment could be instituted.

In subsequent discussions, only those children with a definite diagnosis of epilepsy were seen in the clinics.

A total of 438 patients had a diagnosis of epilepsy without additional complications. This does not necessarily imply that all of these children had idiopathic epilepsy, but it does mean that, at the time of the initial examination, the child showed no handicapping condition other than seizures. Patients in this group may have suffered anoxia or a cerebral injury at birth, but the history was too unreliable to classify them as such.

251, or 36 per cent, of the patients had other major handicaps such as cerebral palsy or mental retardation, in addition to epilepsy. This considerable proportion underscores the fallacy of a restrictive or rigid diagnostic approach to crippling conditions. Many children have multiple handicaps and should be considered from the point of view of the whole child. For example—in order to provide adequate service for a child with cerebral palsy, it is necessary to include the control of seizures.

The number of patients with minor and psychomotor seizures seems unduly small and perhaps indicates the need to sharpen case-finding techniques and to intensify educational efforts in the communities. Many parents or teachers, for example, notice staring spells but consider them to be inattention and do not seek professional help.

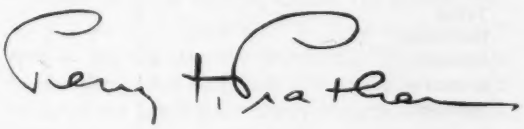
There were 38 known instances in which the fathers of these children had a history of seizures and 50 in which the mothers had a known history of seizures. Of the possible total of 1,378 parents, this represents 88 known instances or 6 per cent.

The degree of success in the control of seizures depends largely on the early diagnosis and instigation of treatment. A comparison of the age of onset of seizures and the age of the first visit to clinic showed that 31 per cent of the patients visited the clinic within a two year period after onset, and that 27 per cent were seen in the next two year period. It is expected that with the service well established and with increased community knowledge the age at first visit will more closely approximate the age of onset.

Using the overall national figure of 1 in 200 however, it is estimated that there are approximately 2,788 patients in Maryland under 21 years of age with epilepsy. After 2½ years of service in the 12 counties where local clinics were established, 34 per cent of the expected number were known. In the counties where there were no local clinics only 14.5 per cent of the expected number were known to the program.

In a few counties with an intensive program the incidence of proved cases closely approximates the expected incidence. It appears that specialized services are needed and used more in remote areas. It also appears that high quality diagnostic clinics have a tremendous case-finding value.

The epilepsy clinics have become a vital and integral part of the generalized public health program in 12 counties in Maryland.



Director

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, March 1–28, 1957

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	99	—	7	—	2	—	58	—	—	—	26	—	—	1	7	—	3	—	8
Anne Arundel	1	—	2	—	5	—	10	—	—	—	2	—	—	1	2	—	2	m-2	5
Howard	—	—	—	—	—	—	1	—	—	—	2	—	—	—	2	—	—	—	1
Harford	—	—	—	—	—	—	—	—	—	—	3	—	—	—	6	—	—	—	—
Carroll	3	—	—	—	—	—	1	—	—	—	14	—	—	—	—	—	—	—	4
Frederick	—	—	—	—	—	—	—	—	—	—	1	—	—	—	2	—	2	—	7
Washington	3	—	—	—	—	—	—	—	—	—	1	—	—	—	2	—	1	—	1
Allegany	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Montgomery	75	—	6	1	22	—	142	—	—	—	22	—	—	—	2	1	6	e-1	5
Prince George's	17	—	2	—	20	1	38	—	—	—	6	—	—	1	6	1	—	e-1 c-1	8
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—
Charles	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Saint Mary's	10	—	7	—	1	—	1	—	—	—	—	—	—	—	1	—	—	—	1
Cecil	1	—	—	2	—	—	—	—	—	—	4	—	—	—	2	—	—	—	1
Kent	—	—	—	—	—	—	3	—	—	—	3	—	—	—	—	—	—	—	1
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—
Caroline	2	—	—	—	1	—	4	—	—	—	—	—	—	—	—	—	1	—	—
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Dorchester	—	—	—	—	1	—	—	—	—	—	—	—	—	—	2	—	—	—	3
Wicomico	9	—	—	6	23	—	10	—	—	—	1	—	—	—	1	—	—	—	2
Worcester	1	—	—	3	9	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	3
Total Counties	221	0	24	12	74	1	268	0	0	0	85	0	0	4	38	2	19*		52
Baltimore City	200	0	9	3	12	0	119	0	0	0	43	0	0	13	107	21	462	t-1	25
State																			
March 1–28, 1957	421	0	33	15	86	1	387	0	0	0	128	0	0	17	145	23	481		77
Same period 1956	420	0	121	15	2095	4	418	0	0	0	120	0	0	13	155	24	440		75
5-year median	565	1	90	34	1250	5	286	0		0	278	1	1	21	178	18	440		81
Cumulative totals																			
State																			
Year 1957 to date	1235	1	64	38	202	8	855	0	0	0	333	1	0	59	459	63	1655		216
Same period 1956	1289	0	258	36	6203	17	1034	1	0	0	344	1	0	51	532	82	1528		265
5-year median	1569	3	192	102	3550	19	755	3		0	722	4	4	89	517	60	1688		255

c = congenital syphilis, under 1 year of age
e = encephalitis, from chicken pox and mumps
m = meningitis, other than meningococcus
t = tetanus
* = Total includes 2 cases from State Institutions.

Blue Cross - Blue Shield

PRESIDENT'S REPORT*
MARYLAND MEDICAL SERVICE, INC.

HENRY F. ULLRICH, M.D., *President*

It is my pleasure to report to you on the progress and development of Maryland's Blue Shield Plan during 1956, our sixth year of operations.

In terms of membership growth, substantial gains were made in 1956, adding a net of 43,337 subscribers to our standard program, bringing the year-end membership total to 273,803. Including the subscribers covered under the special Bethlehem Steel plan, total membership at the end of 1956 was 390,323. This represents 41 per cent of total Blue Cross membership at the year-end.

Enrollment growth has been most encouraging and many large industrial groups have been added. We expect further substantial gains in the year ahead as more and more people realize the value of prepaid protection for in-hospital surgical-medical care. Through our direct enrollment efforts as well as through the public education program via paid radio and newspaper advertising, Blue Shield is becoming much better known and accepted every day.

With our membership growth we have grown financially—in assets, in income, and in payments for services. The total assets of the Corporation, just over the million dollar mark at the end of 1955, rose to $1,839,028 as of December 31, 1956. Our total income in 1956 was $4,144,244, and out of this we paid $3,412,228, or 82.3 per cent, in benefits for subscribers. After operating expenses, which were 9.6 per cent of our total income, we were able to put aside 8.1% in reserves. Additions to contingency reserves were slightly less than in the previous year on a percentage basis, but higher in dollar amount.

Last year we provided benefits under our standard program to 36,095 subscribers, as compared with 23,305 receiving benefits in the previous year. Of the hospitalized cases, 55 per cent included surgery, 30 per cent were medical admissions, and the remaining 15 per cent were obstetrical cases. Thirty-two per cent of the subscribers also received benefits for the additional services of anesthesia, consultations, radiation therapy, and emergency x-ray.

In May 1956, several changes were made in the Blue Shield program, including upward adjustments in certain of the scheduled fees and the addition of benefits for emergency x-ray and radiation therapy services. These, and other changes, have been favorably received by subscribers and physicians alike and have served to make Blue Shield coverage more comprehensive in scope and more equitable to all concerned.

We had planned to present in 1956 a second Blue Shield Plan with higher benefit schedule and higher income limits, to be offered to groups that desire broader protection than we now provide. Work on this new plan had to be postponed temporarily because of the negotiations on the Government's "Medicare" program, but we are again proceeding with it and confidently hope to be able to make a public offering by mid-1957. As pointed out in my letter of January 24th to all participating physicians, this new program will not replace the present one, but will be offered separately to those groups which want it. We will have two Blue Shield Plans—similar to the alternative programs now available through many of the larger Blue Shield Plans in other parts of the country.

At the request of the Medical and Chirurgical Faculty, your Corporation agreed to serve as the fiscal or administrative agent for the Government's Dependent Medical Care Program in Maryland. This program, referred to as "Medicare," provides comprehensive medical and hospital care benefits for dependents of members of the armed forces, at little or no cost to the recipient of the care. It is not an insurance program and your Blue Shield Plan is simply acting as agent, receiving and paying the claims, and being reimbursed by the Government for all payments, plus administrative expenses. Its operations present many new complications and problems, both for the doctors and for the Plan, but

*Given at the Seventh Annual Meeting of Maryland Medical Service, Inc., February 27, 1957.

we are doing our best to make it operate smoothly and efficiently.

The success of Blue Shield in Maryland is due in no small part to the outstanding help and cooperation we have received from physicians. In order to realize full value from this cooperation, we inaugurated an active program of physician relations during 1956. Under this program, we have held a series of meetings in the counties with doctors' secretaries, have met with various groups of physicians, and have personally called on several hundred doctors at their offices. The results have been rewarding in terms of better general understanding of Blue Shield, its aims, and its administrative procedures.

While not necessarily a direct result of this educational program, it is interesting to note that the number of participating physicians in the State increased steadily during the year to over 2,230 at the year-end. Our records show that in 1956, 96 per cent of our payments for services rendered by Maryland physicians were made to participating physicians, and only 4 per cent to those not participating in the program. I am certain that the success we have achieved has been due in large measure to the participation and cooperation of the doctors in Maryland.

In closing, may I extend special thanks to the members of the Board of Trustees, to the members of our Medical Relations and Reference and Appeals Committees, and to other physicians on whom we have called from time to time, who have all given freely and willingly of their time to assist the Plan's administrative staff in making the program operate effectively and smoothly. Many problems lie ahead, but I am confident that with the continued assistance and cooperation of all physicians, we will move ahead to new records of growth in 1957.

DR. MELITTA SCHMIDEBERG TO SPEAK

The Department of Psychology of Springfield State Hospital announces that the Virginia Beyer Memorial Lecturer for 1957 will be Melitta Schmideberg, M.D.

The Virginia Beyer Lecture is now in its third year and was originally created to honor the late Clinical Director of Springfield State Hospital.

The topic this year will be "Psychotherapy and the Therapeutic Management of Delinquents."

The lecture will take place on May 24th and 25th. Registration fee is $10.00. For further information write to Dr. Michael H. P. Finn, Ph.D., Chief Psychologist, Springfield State Hospital, Sykesville, Maryland.

Woman's Auxiliary Medical and Chirurgical Faculty

MRS. GERALD W. LEVAN, *Auxiliary Editor*

EIGHTH ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY

The Eighth Annual Convention of the Woman's Auxiliary to the Medical and Chirurgical Faculty will be held at the Sheraton-Belvedere Hotel, Baltimore, May 1 and 2, 1957.

The Convention program will include both business sessions and social activities, which we think all doctors' wives will enjoy. As we go to press two months in advance, it is not possible to give you the complete convention program at this time, but you can be assured that it will be a most interesting and inspiring one. So, you are urged to honor us with your presence at all functions.

Governor Theodore R. McKeldin and Mrs. Paul C. Craig, President-Elect of the Woman's Auxiliary to the American Medical Association, will be our guest speakers this year. And, we do not want you to miss either of these talks.

The Woman's Auxiliary of Baltimore City has arranged for us a trip to Annapolis on our second day of the convention, when we will be the honored guests of Mrs. Theodore McKeldin, Maryland's First Lady, at a Tea. Surely, you will not want to miss this opportunity!

Your State President and her Hospitality Chairman await the opportunity to extend to you—each and every doctor's wife—a warm and sincere welcome to the Eighth Annual Convention.

WOMAN'S AUXILIARY TO THE WASHINGTON COUNTY MEDICAL SOCIETY

The Woman's Auxiliary to the Washington County Medical Society held its first general meeting of the current year at the Fountain Head Country Club on Wednesday, February 13. A luncheon preceded the business meeting, which was conducted by the retiring president, Mrs. B. B. Kneisley. Annual reports were given by the officers and committee chairmen.

The meeting was highlighted by the installation of new officers for 1957. Mrs. Kneisley introduced our State President, Mrs. Homer U. Todd, Sr., who honored the local group by installing their newly elected officers. Mrs. Albert Goldstein, a past president of the state auxiliary was also an honored guest, and she spoke briefly on the Auxiliary Newsletter.

The retiring president, Mrs. Kneisley, very graciously thanked her staff for their cooperation and work during the past year, and turned the meeting over to the new president, Mrs. Jake Warden, who introduced the various committee chairmen for 1957 and outlined her program for the year.

WOMAN'S AUXILIARY TO THE WASHINGTON COUNTY MEDICAL SOCIETY

Officers 1957

President
Mrs. J. G. Warden
922 Dewey Avenue
Hagerstown

President-Elect, 1st Vice President
Mrs. Ross Cameron
909 Rolling Road
Hagerstown

2nd Vice President
Mrs. Robert Conrad
928 The Terrace
Hagerstown

Recording Secretary
Mrs. V. Harwood Link
947 Mulberry Avenue
Hagerstown

Corresponding Secretary
Mrs. J. H. Ramsey
806 Rolling Road
Hagerstown

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Mrs. Archie Cohen
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Main Street
Clear Spring

Recruitment
Mrs. D. J. Boyer
1552 Dual Highway
Hagerstown

Future Nurses Clubs
Mrs. B. B. Kneisley
148 W. Washington Street
Hagerstown

Hospitality
Mrs. Frederick Graff
1041 Woodland Way
Hagerstown

Program
Mrs. Philip J. Hirshman
1110 Oak Hill Avenue
Hagerstown

Doctors' Day
Mrs. Gerald W. LeVan
32 So. Main Street
Boonsboro

Safety
Mrs. Robert Conrad
928 The Terrace
Hagerstown

CIVIL DEFENSE

MRS. HOMER U. TODD, SR.

We are facing the threat of attack upon our cities with the weapons of modern war, among them the H-bomb. There is only one practical defense against a bomb capable of knocking out a city—planned, orderly evacuation, before an attack. This is Civil Defense's answer. It has been endorsed by the President and the National Security Council and our military leaders. Now more than ever do we need alert, informed people, trained in the techniques of survival.

We formerly depended upon shelters as defense against A-bombs. Today we must get people out of the congested areas of our communities, if they are to be saved. Generally these congested areas are the most likely target for enemy bombers.

Civil Defense is everyone's responsibility. Practice and rehearsal form a pattern we follow automatically in case of emergency. Therefore, our aims should be to complete the First Aid and Nursing courses with the newer methods taught and be well versed in all phases of Civil Defense so as to make an effective response in case of man-made or natural disaster.

Be an asset, not a liability in case of attack.

The Auxiliary has a Committee on Civil Defense, of which Mrs. Lester T. Chance is the Chairman.

Coming Meetings

MAY 1957

PATHOLOGY SECTION, B.C.M.S.

Saturday, May 4, 9:00 A.M.

Public Health Service, Clinical Centre, Bethesda, Maryland

* * * *

COMMITTEE FOR THE STUDY OF PELVIC CANCER

Thursday, May 15, 5:00 P.M.

To be announced

* * * *

JOINT COMMITTEE ON MATERNAL MORTALITY, CITY HEALTH DEPT. AND B.C.M.S.

Thursday, May 23, 4:00 P.M.

1211 Cathedral Street

All meetings are held in the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore, Md., unless otherwise designated.

Television and radio programs presented in conjunction with the Baltimore City Health Department and the Medical and Chirurgical Faculty:

TELEVISION STATION WMAR-TV

"YOUR FAMILY DOCTOR"

Friday 5:15 P.M.

May 3	Skin Ailments	Dr. Harry Robinson
10	Prenatal Care	Miss Volmar
17	There's Always A Way	Dr. Mandell
24	Gall Bladder Disease	Dr. C. Reid Edwards
31	The Health Department's Birth Record Correction Service	Mr. Norton

RADIO STATION WFBR

"KEEPING WELL"

Monday 10:15 P.M.

May 6	Working Mother	Miss Volmar
13	There's Always A Way	Dr. Mandell
20	The Stone That Grew	Dr. C. Reid Edwards
27	These Are The Facts (Birth Record Correction Service)	Mr. Norton

AMERICAN PSYCHIATRIC ASSOCIATION

A Statement on the Contribution of the Tranquilizing Drugs to the Treatment of Psychiatric Illnesses and the Dangers Inherent in the Casual Use of These Drugs by the Public for the Relief of Everyday Tensions

Prepared by the Committees on Research, Therapy, and Public Information of the American Psychiatric Association. Distributed to all members for their information and consideration with the approval of the Executive Committee, June 16, 1956.

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The profession of psychiatry recognizes with enthusiasm the development of the tranquilizing and other drugs for the treatment of psychiatric disorders over the past four years. The evidence is that these drugs are effective in making disturbed patients in mental hospitals more readily accessible to treatment. This has made possible impressive advances in mental hospital treatment programs and increased discharge rates. Further, by making patients more comfortable, the drugs have contributed greatly to improving the atmosphere and the management of mental hospitals. It seems clear also that the drugs on an outpatient basis in clinics and hospitals, though the extent and the conditions under which this practice will prove sound remains to be confirmed through prolonged and careful study.

Psychiatrists are at the same time concerned about the apparently widespread use of the drugs by the public for the relief of common anxiety, emotional upsets, nervousness, and the routine tensions of everyday living. It is reported that 35,000,000 prescriptions for the drugs will be written in 1956, and a market research firm states that 3 of 10 compounds prescribed most frequently by physicians in 1955 were tranquilizers.* Numerous articles in the public prints may be pointed to as evidence that the drugs are widely viewed as medicines for the relief of everyday tensions.

Casual use of the drugs in this manner is medically unsound and constitutes a public danger. The tranquilizing drugs have not been in use long enough to determine the full range, duration, and medical significance of their side effects. Use of these drugs is no more to be encouraged than use of any other drug except where proper medical diagnosis determines that a drug is indicated to maintain the life and functioning of a person. The prescribing of the drugs for emotional illnesses carries with it an obligation for continuing appraisal and supervision by physicians fully aware of the psychiatric symptoms involved and the potentials of their course of development, alteration or remission.

The full cooperation of the profession in accumulating a body of tested scientific data about the drugs is of prime importance. The launching of comprehensive research programs for the evaluation of the drugs is to be encouraged. This includes such a program as that recently announced by the Veterans Administration, and the programs planned by the National Research Council with the U. S. Public Health Service, and state-wide programs as well.

At the same time, it is important to be aware of subtle pressures that combine to foster public misunderstanding and misuse of the drugs. There is the eagerness of the public, and of physicians themselves, for "good news" about a new treatment for psychiatric disorders. This tends to foster popular stories based on optimistic reports of early and limited research findings with the drugs, before such findings can be reproduced and validated by other colleagues. There is normal competition among pharmaceutical houses to refine, promote, and sell their own particular products. This competition should not involve physicians in public relations enterprises directed towards the premature announcement of "successful use" of particular products.

Persons engaged in any form of research or evaluation of therapy should be most dispassionate and objective in their pronouncements. It is suggested that Members of the Association be particularly alert to personal pressures (both internal and external) and circumspect in their announcements of early experimental results with the drugs.

* Press Release, Affiliated Public Relations, 342 Madison Avenue, New York 17, N. Y., June 7, 1956.